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DEPARTMENT OF DEFENSE

Office of the Assistant Secretary of Defense
(Health Affairs)

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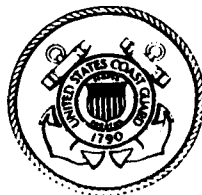
Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

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Assistant Secretary of Defense (Health Affairs)

DoD 6010.8-R - REPRINT
July 12, 1991

CIVILIAN HEALTH AND MEDICAL PROGRAM
OF THE UNIFORMED SERVICES (CHAMPUS)

DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," March 1986, has been superseded by the attached reprint. This reprint incorporates changes 1 through 26 and is dated July 1991.

Because of the publication of this reprint, Change no. 26 was not published as a separate change. Change no. 26 issued a new chapter 16 and pages vii, 6-i, 6-3, and 6-5, which were affected by this Change, contain marginal bars. These pages and chapter 16 were effective June 1, 1991.

EFFECTIVE DATE

This reprint is effective immediately.

James L Elmer
JAMES L. ELMER
Director
Correspondence and Directives

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DEPARTMENT OF DEFENSE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF TRANSPORTATION
WASHINGTON, D.C.

March 10, 1986

FOREWORD

This Regulation is issued under the authority of DoD Instruction 6010.8, "Administration of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," October 24, 1984. It corrects typographical errors, updates references, and incorporates substantive coordinated or mandated changes issued since its original publication. Its purpose is to prescribe uniform policy for the worldwide operation of CHAMPUS, and to provide guidelines for an equitable delivery of authorized health care benefits to all beneficiaries.

DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," January 10, 1977, is hereby canceled.

This Regulation applies to the Office of the Secretary of Defense (OSD), the Military Departments, the Organization of the Joint Chiefs of Staff, the Unified and Specified Commands, and the Defense Agencies (hereafter referred to collectively as "DoD Components"), the U.S. Coast Guard (CG), the Commissioned Corps of the U.S. Public Health Service (USPHS), and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA) (hereafter referred to collectively as the "other Uniformed Services").

This Regulation is effective immediately and is mandatory for use by DoD Components, CG, USPHS, and NOAA.

Forward recommended changes to this Regulation through channels to the
Director, OCHAMPUS
Aurora, Colorado 80045-6900

DoD Components and the other Uniformed Services may obtain copies of this Regulation through their own publication channels. Other Federal agencies and the public may obtain copies from the U.S. Department of Commerce, National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161.

Records responsibility for this Regulation is assigned to the Department of Defense. This responsibility includes the retirement of records and the publication of changes.

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GENERAL PROVISIONS

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CHAPTER 1
GENERAL PROVISIONS

A. PURPOSE

This Regulation prescribes guidelines and policies for the administration of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) for the Army, the Navy, the Air Force, the Marine Corps, the Coast Guard, the Commissioned Corps of the U.S. Public Health Service (USPHS) and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA).

B. APPLICABILITY

1. Geographic. This Regulation is applicable geographically within the 50 States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, and the United States possessions and territories, and in all foreign countries, unless specific exemptions are granted in writing by the Director, OCHAMPUS, or a designee.

2. Agency. The provisions of this Regulation apply throughout the Department of Defense (DoD), the Coast Guard, the Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA.

C. AUTHORITY AND RESPONSIBILITY

1. Legislative authority

a. Joint regulations. 10 U.S.C., Chapter 55 (reference (a)), authorizes the Secretary of Defense, the Secretary of Health and Human Services, and the Secretary of Transportation jointly to prescribe regulations for the administration of CHAMPUS.

b. Administration. 10 U.S.C., Chapter 55 (reference (a)), also authorizes the Secretary of Defense to administer CHAMPUS for the Army, Navy, Air Force, and Marine Corps under DoD jurisdiction, the Secretary of Transportation to administer CHAMPUS for the Coast Guard, when the Coast Guard is not operating as a service in the Navy, and the Secretary of Health and Human Services to administer CHAMPUS for the Commissioned Corps of the NOAA and the USPHS.

2. Organizational delegations and assignments

a. Assistant Secretary of Defense (Health Affairs)(ASD(HA)). The Secretary of Defense, by DoD Directive 5136.1 (reference (b)), delegated authority to the ASD(HA) to provide policy guidance, management control and coordination as required for CHAMPUS, and to develop, issue, and maintain regulations with the coordination of the Military Departments and consistent with DoD 5025.1-M (reference (c)). Additional implementing authority is contained in DoD Directive 5105.46 (reference (d)).

b. Department of Health and Human Services. The Secretary of Health and Human Services has delegated authority to the Assistant Secretary for Health, DHHS, to consult with the Secretary of Defense or a designee and to

approve and issue joint regulations implementing 10 U.S.C., Chapter 55 (reference (a)). This delegation was effective April 19, 1976 (41 FR 18698, May 6, 1976).

c. Department of Transportation. The Secretary of Transportation has delegated authority to the Commandant, United States Coast Guard, to consult with the Secretary of Defense or a designee and to approve and issue joint regulations implementing 10 U.S.C., Chapter 55 (reference (a)).

d. Office of CHAMPUS (OCHAMPUS). By DoD Directive 5105.46 (reference (d)), OCHAMPUS was established as an OSD field activity under the policy guidance and direction of the ASD(HA). The Director, OCHAMPUS, is directed to execute the following responsibilities and functions:

(1) Supervise and administer the programs and missions to:

(a) Provide technical direction and guidance on organizational, administrative, and operational matters.

(b) Conduct studies and research activities in the health care area to assist in formulating policy required to guide OCHAMPUS in carrying out its programs.

(c) Enter into agreements through the Department of Defense with respect to the Military Departments or other U.S. Government entities, as required, for the effective performance of CHAMPUS.

(d) Supervise and administer OCHAMPUS financial management activities to include:

1 Formulating budget estimates and justifications to be submitted to the Deputy Assistant Secretary of Defense (Administration) (DASD(A)) for inclusion in the overall budget for the Office of the Secretary of Defense.

2 Ensuring the establishment and maintenance of necessary accounting records and the submission of required financial reports to the DASD(A).

3 Ensuring the effective execution of approved budgets.

(e) Contract for claims processing services, studies and research, supplies, equipment, and other services necessary to carry out the CHAMPUS programs.

(f) Monitor claims adjudication and processing contracts to ensure that CHAMPUS fiscal intermediaries are fulfilling their obligations.

(g) Convey appropriate CHAMPUS information to providers of care, practitioners, professional societies, health industry organizations, fiscal agents, hospital contractors, and others who have need of such information.

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(h) Collect, maintain, and analyze program cost and utilization data appropriate for preparation of budgets, fiscal planning, and as otherwise needed to carry out CHAMPUS programs and missions.

(i) Arrange for the facilities logistical and administrative support to be provided by the Military Departments.

(j) Execute such other functions as appropriate to administer the programs and missions assigned.

(2) Direct and control the office, activities, and functions of OCHAMPUS Europe (OCHAMPUSEUR).

NOTE: The Director, OCHAMPUS, may also establish similar offices for OCHAMPUS Southern Hemisphere (OCHAMPUSSO) and OCHAMPUS Pacific (OCHAMPUSPAC).

(3) Develop for issuance, subject to approval by the ASD(HA), such policies or regulations as required to administer and manage CHAMPUS effectively.

e. Evidence of eligibility. The Department of Defense, through the Defense Enrollment Eligibility Reporting System (DEERS), is responsible for establishing and maintaining a listing of persons eligible to receive benefits under CHAMPUS. Identification cards or devices bearing information necessary for preliminary evidence of eligibility, subject to verification through the DEERS, shall be issued to eligible persons by the appropriate Uniformed Service (DoD 1341.1-M, reference (e)).

D. MEDICAL BENEFITS PROGRAM

The CHAMPUS is a program of medical benefits provided by the U.S. Government under public law to specified categories of individuals who are qualified for these benefits by virtue of their relationship to one of the seven Uniformed Services. Although similar in structure in many of its aspects, CHAMPUS is not an insurance program in that it does not involve a contract guaranteeing the indemnification of an insured party against a specified loss in return for a premium paid. Further, CHAMPUS is not subject to those state regulatory bodies or agencies that control the insurance business generally.

E. PROGRAM FUNDS

The funds used by CHAMPUS are appropriated funds furnished by the Congress through the annual appropriation acts for the Department of Defense and the DHHS. These funds are further disbursed by agents of the government under contracts negotiated by the Director, OCHAMPUS, or a designee, under the provisions of the Federal Acquisition Regulation (FAR) (reference (f)). These agents (referred to in this Regulation as CHAMPUS fiscal intermediaries) receive claims against CHAMPUS and adjudicate the claims under this Regulation and in accordance with administrative procedures and instructions prescribed in their contracts. The funds expended for CHAMPUS benefits are federal funds provided

CHAMPUS fiscal intermediaries solely to pay CHAMPUS claims, and are not a part of or obtained from the CHAMPUS fiscal intermediary's funds related to other programs or insurance coverage. CHAMPUS fiscal intermediaries are reimbursed for the adjudication and payment of CHAMPUS claims at a rate (generally fixed-price) prescribed in their contracts.

F. CLAIMS ADJUDICATION AND PROCESSING

The Director, OCHAMPUS, is responsible for making such arrangements as are necessary to adjudicate and process CHAMPUS claims worldwide.

1. The United States

a. Contracting out. The primary method of processing CHAMPUS claims in the United States is through competitively procured, fixed-price contracts. The Director, OCHAMPUS, or a designee, is responsible for negotiating, under the provisions of the FAR (reference (f)), contracts for the purpose of adjudicating and processing CHAMPUS claims (and related supporting activities).

b. In-house. The Director, OCHAMPUS, or a designee, is authorized to adjudicate and process certain CHAMPUS claims in-house at OCHAMPUS, when it is determined to be in the best interests of CHAMPUS subject to applicable considerations set forth in OMB Circular A-76 (reference (g)). Such in-house claims processing may involve special or unique claims, or all claims for a specific geographic area.

2. Outside the United States

a. Special subsidiary office or contracting out. For adjudicating and processing CHAMPUS claims for services or supplies provided outside the United States, the Director, OCHAMPUS, or a designee, has the option of either setting up a special subsidiary claims paying operation (such as OCHAMPUSEUR) or contracting out as described in paragraph F.1.a. of this chapter. Such claims paying operations are reviewed periodically to determine whether current arrangements continue to be appropriate and the most effective.

b. Support agreements. In those situations outside the United States that demand special arrangements, the Director, OCHAMPUS, may enter into support agreements through the Department of Defense with any of the Military Departments or other government agency to process CHAMPUS claims in specific geographic locations. Such agreements may be negotiated for such period of time as the Director, OCHAMPUS, or designee, may determine to be necessary to meet identified special demands.

G. RECOMMENDATIONS FOR CHANGE TO REGULATION

The Director, OCHAMPUS, or a designee, shall establish procedures for receiving and processing recommendations for changes to this Regulation from interested parties.

H. CHAMPUS CLAIMS FORMS

The Director, OCHAMPUS, or a designee, is responsible for the development and updating of all CHAMPUS claim forms and any other forms necessary in the administration of CHAMPUS.

I. THE CHAMPUS HANDBOOK

The Director, OCHAMPUS, or a designee, shall develop the CHAMPUS Handbook. The CHAMPUS Handbook is a general program guide for the use of CHAMPUS beneficiaries and providers and shall be updated, as required.

J. PROGRAM INTEGRITY

The Director, OCHAMPUS, or a designee, shall oversee all CHAMPUS personnel, fiscal intermediaries, providers, and beneficiaries to ensure compliance with this Regulation. The Director, OCHAMPUS, or a designee, shall accomplish this by means of proper delegation of authority, separation of responsibilities, establishment of reports, performance evaluations, internal and external management and fiscal audits, personal or delegated reviews of CHAMPUS responsibilities, taking affidavits, exchange of information among state and federal governmental agencies, insurers, providers and associations of providers, and such other means as may be appropriate. Compliance with law and this Regulation shall include compliance with specific contracts and agreements, regardless of form, and general instructions, such as CHAMPUS policies, instructions, procedures, and criteria relating to CHAMPUS operation.

K. ROLE OF CHAMPUS HEALTH BENEFITS ADVISOR (HBA)

The CHAMPUS HBA is appointed (generally by the commander of a Uniformed Services medical treatment facility) to serve as an advisor to patients and staff in matters involving CHAMPUS. The CHAMPUS HBA may assist beneficiaries or sponsors in applying for CHAMPUS benefits, in the preparation of claims, and in their relations with OCHAMPUS and CHAMPUS fiscal intermediaries. However, the CHAMPUS HBA is not responsible for CHAMPUS policies and procedures and has no authority to make benefit determinations or obligate Government funds. Advice given to beneficiaries as to determination of benefits or level of payment is not binding on OCHAMPUS or CHAMPUS fiscal intermediaries.

L. COOPERATION AND EXCHANGE OF INFORMATION WITH OTHER FEDERAL PROGRAMS

The Director, OCHAMPUS, or a designee, shall disclose to appropriate officers or employees of the DHHS:

1. Investigation for fraud. The name and address of any physician or other individual actively being investigated for possible fraud in connection with CHAMPUS, and the nature of such suspected fraud. An active investigation exists when there is significant evidence supporting an initial complaint but there is need for further investigation.

2. Unnecessary services. The name and address of any provider of medical services, organization, or other person found, after consultation with an appropriate professional association or appropriate peer review body, to have provided unnecessary services. Such information will be released only for the purpose of conducting an investigation or prosecution, or for the administration of titles XVIII and XIX of the Social Security Act (reference (h)), provided that the information will be released only to the agency's enforcement branch and that the agency will preserve the confidentiality of the information received and will not disclose such information for other than program purposes.

M. DISCLOSURE OF INFORMATION TO THE PUBLIC

Records and information acquired in the administration of CHAMPUS are records of the Department of Defense and may be disclosed in accordance with DoD Directive 5400.7, DoD 5400.7-R, and DoD 5400.11-R (references (i), (j), and (k) and codified in 32 CFR Parts 286 and 286a), constituting the applicable DoD Directives and DoD Regulations implementing the Freedom of Information and the Privacy Acts.

N. DISCRETIONARY AUTHORITY

When it is determined to be in the best interest of CHAMPUS, the Director, OCHAMPUS, or a designee, is granted discretionary authority to waive any requirements of this Regulation, except that any requirement specifically set forth in 10 U.S.C., Chapter 55 (reference (a)), or otherwise imposed by law, may not be waived. It is the intent that such discretionary authority be used only under very unusual and limited circumstances and not to deny any individual any right, benefit, or privilege provided to him or her by statute or this Regulation. Any such exception granted by the Director, OCHAMPUS, or a designee, shall apply only to the individual circumstance or case involved and will in no way be construed to be precedent-setting.

O. DEMONSTRATION PROJECTS

1. Authority. The Director, OCHAMPUS, may waive or alter any requirements of this Regulation in connection with the conduct of a demonstration project required or authorized by law except for any requirement that may not be waived or altered pursuant to 10 U.S.C., Chapter 55 (reference (a)), or other applicable law.

2. Procedures. At least 30 days prior to taking effect, OCHAMPUS shall publish a notice describing the demonstration project, the requirements of this Regulation being waived or altered under the above subsection O.1. and the duration of the waiver or alteration. Consistent with the purpose and nature of demonstration projects, these notices are not covered by public comment practices under DoD Directive 5400.9 (32 CFR Part 296) or DoD Instruction 6010.8.

3. Definition. For purposes of this section O., a "demonstration project" is a project of limited duration designed to test a different method for the finance, delivery or administration of health care activities for the Uniformed Services. Demonstration projects may be required or authorized by 10 U.S.C. 1092, any other statutory provision requiring or authorizing a demonstration project or any other provision of law that authorizes the activity involved in the demonstration project.

P. MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM.

The Secretary of Defense, or designee, may enter into an agreement (external or internal) providing for the sharing of resources between facilities of the uniformed services and facilities of a civilian health care provider or providers if the Secretary determines that such an agreement would result in the delivery of health care in a more effective, efficient or economical manner. This partnership allows CHAMPUS beneficiaries to receive inpatient and outpatient services through CHAMPUS from civilian personnel providing health care services in military treatment facilities and from uniformed service professional providers in civilian facilities. The policies and procedures by which partnership agreements may be executed are set forth in Department of Defense Instruction (DoDI) 6010.12, "Military-Civilian Health Services Partnership program." The Director, OCHAMPUS, or a designee, shall issue policies, instructions, procedures, guidelines, standards, or criteria as may be necessary to:

- provide support for implementation of DoDI 6010.12;
- to promulgate and manage benefit and financial policy issues; and
- to develop a program evaluation process to ensure the Partnership Program accomplishes the purpose for which it was developed.

1. Partnership agreements. Military treatment facility commanders, based upon the authority provided by their respective Surgeons General of the military departments, are responsible for entering into individual partnership agreements only when they have determined specifically that use of the Partnership Program is more economical overall to the Government than referring the need for health care services to the civilian community under the normal operation of the CHAMPUS Program. All such agreements are subject to the review and approval of the Director, OCHAMPUS, or designee, and the appropriate Surgeon General.

a. External partnership agreements. The external partnership agreement is an agreement between a military treatment facility commander and a CHAMPUS-authorized institutional provider, enabling Uniformed Services health care personnel to provide otherwise covered medical care to CHAMPUS beneficiaries in a civilian facility. Authorized costs associated with the use of the facility will be financed through CHAMPUS under normal cost-sharing and reimbursement procedures currently applicable under the basic CHAMPUS. Savings will be realized under this type agreement by using available military health care personnel to avoid the civilian professional provider charges which would otherwise be billed to CHAMPUS.

b. Internal partnership agreements. The internal partnership agreement is an agreement between a military treatment facility commander and a CHAMPUS-authorized civilian health care provider which enables the use of civilian health care personnel or other resources to provide medical care to CHAMPUS beneficiaries on the premises of a military treatment facility. These internal agreements may be established when a military treatment facility is unable to provide sufficient health care services for CHAMPUS beneficiaries due to shortages of personnel and other required resources. In addition to allowing the military treatment facility to achieve maximum use of available facility space, the internal agreement will result in savings to the Government by using civilian medical specialists to provide inpatient care in Government-owned facilities, thereby avoiding the civilian facility charges which would have otherwise been billed to CHAMPUS.

2. Beneficiary cost-sharing. Beneficiary cost-sharing under the Partnership Program is outlined in paragraph F.5. of Chapter 4 of this Regulation.

3. Reimbursement. Reimbursement under the Partnership Program is outlined in paragraph F. of Chapter 14 of this Regulation.

4. Beneficiary eligibility and authorized providers. Existing requirements of this Regulation remain in effect as concerns beneficiary eligibility and authorized providers.

5. Range of benefits. Health care services provided CHAMPUS beneficiaries under the terms of the Partnership Program must be consistent with the CHAMPUS range of benefits outlined in this Regulation. The services rendered must be otherwise covered. Charges allowed for professional services provided under the Partnership Program may include costs of support personnel, equipment, and supplies when specifically outlined in the partnership agreement. However, all CHAMPUS coverage and provider requirements must be met.

Q. EQUALITY OF BENEFITS

All claims submitted for benefits under CHAMPUS shall be adjudicated in a consistent, fair, and equitable manner, without regard to the rank of the sponsor.

CHAPTER 2

DEFINITIONS

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CHAPTER 2 DEFINITIONS

A. GENERAL

In an effort to be as specific as possible as to the word and intent of CHAMPUS, the following definitions have been developed. While many of the definitions are general and some assign meaning to relatively common terms within the health insurance environment, others are applicable only to CHAMPUS; however, they all appear in this Regulation solely for the purpose of the Program. Except when otherwise specified, the definitions in this chapter apply generally throughout this Regulation.

B. SPECIFIC DEFINITIONS

Abortion. Abortion means the intentional termination of a pregnancy by artificial means done for a purpose other than that of producing a live birth. A spontaneous, missed or threatened abortion or termination of an ectopic (tubal) pregnancy are not included within the term "abortion" as used herein.

Absent Treatment. Services performed by Christian Science practitioners for a person when the person is not physically present. NOTE: Technically, "Absent Treatment" is an obsolete term. The current Christian Science terminology is "treatment through prayer and spiritual means," which is employed by an authorized Christian Science practitioner either with the beneficiary being present or absent. However, to be considered for coverage under CHAMPUS, the beneficiary must be present physically when a Christian Science service is rendered, regardless of the terminology used.

Abuse. For the purposes of this Regulation, abuse is defined as any practice that is inconsistent with accepted sound fiscal, business, or professional practice which results in a CHAMPUS claim, unnecessary cost, or CHAMPUS payment for services or supplies that are: (1) not within the concepts of medically necessary and appropriate care, as defined in this Regulation, or (2) that fail to meet professionally recognized standards for health care providers. The term "abuse" includes deception or misrepresentation by a provider, or any person or entity acting on behalf of a provider in relation to a CHAMPUS claim.

NOTE: Unless a specific action is deemed gross and flagrant, a pattern of inappropriate practice will normally be required to find that abuse has occurred. Also, any practice or action that constitutes fraud, as defined by this Regulation, would also be abuse.

Accidental Injury. Physical bodily injury resulting from an external force, blow or fall, or the ingestion of a foreign body or harmful substance, requiring immediate medical treatment. Accidental injury also includes animal and insect bites and sunstrokes. For the purpose of CHAMPUS, the breaking of a tooth or teeth does not constitute a physical bodily injury.

Active Duty. Full-time duty in the Uniformed Services of the United States. It includes duty on the active list, full-time training duty, annual training duty, and attendance while in the active Military Service, at a school designated as a Service school by law or by the Secretary of the Military Department concerned.

Active Duty Member. A person on active duty in a Uniformed Service under a call or order that does not specify a period of 30 days or less.

Acupuncture. The practice of inserting needles into various body parts to pierce specific peripheral nerves for the production of counter-irritation to relieve the discomfort of pain, induce surgical anesthesia, or for other treatment purposes.

NOTE: Acupuncture is not covered by CHAMPUS.

Adequate Medical Documentation, Medical Treatment Records. Adequate medical documentation contains sufficient information to justify the diagnosis, the treatment plan, and the services and supplies furnished. Under CHAMPUS, it is required that adequate and sufficient clinical records be kept by the health care provider(s) to substantiate that specific care was actually and appropriately furnished, was medically necessary and appropriate (as defined by this Regulation), and to identify the individual(s) who provided the care. All procedures billed must be documented in the records. In determining whether medical records are adequate, the records will be reviewed under the generally acceptable standards such as the applicable Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, the Peer Review Organization (PRO) standards (and the provider's state or local licensing requirements) and other requirements specified by this Regulation. In general, the documentation requirements for a professional provider are not less in the outpatient setting than the inpatient setting.

Adequate Medical Documentation, Mental Health Records. Adequate medical documentation provides the means for measuring the type, frequency, and duration of active treatment mechanisms employed and progress under the treatment plan. Under CHAMPUS, it is required that adequate and sufficient clinical records be kept by the provider to substantiate that specific care was actually and appropriately furnished, was medically or psychologically necessary (as defined by this Regulation), and to identify the individual(s) who provided the care. Each service provided or billed must be documented in the records. In determining whether medical records are adequate, the records will be reviewed under the generally acceptable standards (e.g., the applicable JCAHO standards and the provider's state or local licensing requirements) and other requirements specified by this Regulation. It must be noted that the psychiatric and psychological evaluations, physician orders, the treatment plan, integrated progress notes (and physician progress notes if separate from the integrated progress notes), and the discharge summary are the more critical elements of the mental health record. However, nursing and staff notes, no matter how complete, are not a substitute for the documentation of services by the individual professional provider who furnished treatment to the beneficiary. In general, the documentation requirements of a professional provider are not less in the outpatient setting than the inpatient setting. Furthermore, even though a hospital that provides psychiatric care may be accredited under the JCAHO manual for hospitals rather than the consolidated standards manual, the critical elements of the mental health record listed above are required for CHAMPUS claims.

Adjunctive Dental Care. Dental care that is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition, and is essential to the control of the primary medical condition; or, is required in preparation for or as the result of dental trauma which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic).

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Admission. The formal acceptance by a CHAMPUS authorized institutional provider of a CHAMPUS beneficiary for the purpose of diagnosis and treatment of illness, injury, pregnancy, or mental disorder.

Adopted Child. A child taken into one's own family by legal process and treated as one's own child. In case of adoption, CHAMPUS eligibility begins as of 12:01 a.m. of the day of the final adoption decree. NOTE: There is no CHAMPUS benefit entitlement during any interim waiting period.

All-Inclusive Per Diem Rate. The OCHAMPUS determined rate that encompasses the daily charge for inpatient care and, unless specifically excepted, all other treatment determined necessary and rendered as part of the treatment plan established for a patient, and accepted by OCHAMPUS.

Allowable Charge. The CHAMPUS-determined level of payment to physicians, other individual professional providers and other providers, based on one of the approved reimbursement methods set forth in Chapter 14 of this Regulation. Allowable charge also may be referred to as the CHAMPUS-determined reasonable charge.

Allowable Cost. The CHAMPUS-determined level of payment to hospitals or other institutions, based on one of the approved reimbursement methods set forth in Chapter 14 of this Regulation. Allowable cost may also be referred to as the CHAMPUS-determined reasonable cost.

Ambulance. A specially designed vehicle for transporting the sick or injured that contains a stretcher, linens, first aid supplies, oxygen equipment, and such lifesaving equipment required by state and local law, and that is staffed by personnel trained to provide first aid treatment.

Amount in Dispute. The amount of money, determined under this Regulation, that CHAMPUS would pay for medical services and supplies involved in an adverse determination being appealed if the appeal were resolved in favor of the appealing party. See Chapter 10 for additional information concerning the determination of "amount in dispute" under this Regulation.

Anesthesia Services. The administration of an anesthetic agent by injection or inhalation, the purpose and effect of which is to produce surgical anesthesia characterized by muscular relaxation, loss of sensation, or loss of consciousness when administered by or under the direction of a physician or dentist in connection with otherwise covered surgery or obstetrical care, or shock therapy. Anesthesia services do not include hypnosis or acupuncture.

Appealable Issue. Disputed questions of fact which, if resolved in favor of the appealing party, would result in the authorization of CHAMPUS benefits, or approval as an authorized provider in accordance with this Regulation. An appealable issue does not exist if no facts are in dispute, if no CHAMPUS benefits would be payable, or if there is no authorized provider, regardless of the resolution of any disputed facts. See Chapter 10 for additional information concerning the determination of "appealable issue" under this Regulation.

Appealing Party. Any party to the initial determination who files an appeal of an adverse determination or requests a hearing under the provisions of this Regulation.

Appropriate Medical Care

1. Services performed in connection with the diagnosis or treatment of disease or injury, pregnancy, mental disorder, or well-baby care which are in keeping with the generally accepted norms for medical practice in the United States;

2. The authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training and education and is licensed or certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards; and

3. The services are furnished economically. For purposes of this Regulation, "economically" means that the services are furnished in the least expensive level of care or medical environment adequate to provide the required medical care regardless of whether or not that level of care is covered by CHAMPUS.

Attending Physician. The physician who has the primary responsibility for the medical diagnosis and treatment of the patient. A consultant, an assistant-at-surgery or an anesthesiologist is not an attending physician. Under very extraordinary circumstances, because of the presence of complex, serious, and multiple, but unrelated, medical conditions, a patient may have more than one attending physician concurrently rendering medical treatment during a single period of time.

Authorized Provider. A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized to provide benefits under CHAMPUS in Chapter 6 of this Regulation.

Backup Hospital. A hospital which is otherwise eligible as a CHAMPUS institutional provider and which is fully capable of providing emergency care to a patient who develops complications beyond the scope of services of a given category of CHAMPUS authorized freestanding institutional provider and which is accessible from the site of the CHAMPUS authorized freestanding institutional provider within an average transport time acceptable for the types of medical emergencies usually associated with the type of care provided by the freestanding facility.

Basic Program. The primary medical benefits authorized under Chapter 55 of title 10, United States Code, and set forth in Chapter 4 of this Regulation.

Beneficiary. An individual who has been determined to be eligible for CHAMPUS benefits, as set forth in Chapter 3 of this Regulation.

Beneficiary Liability. The legal obligation of a beneficiary, his or her estate, or responsible family member to pay for the costs of medical care or treatment received. Specifically, for the purposes of services and supplies covered by CHAMPUS, beneficiary liability includes any annual deductible amount, cost-sharing amounts, or, when a provider does not submit a claim on a participating basis on behalf of the beneficiary, amounts above the CHAMPUS-determined allowable cost or charge. Beneficiary liability also includes any expenses for medical or related services and supplies not covered by CHAMPUS.

Birthing Center. A health care provider which meets the applicable requirements established by section B. of Chapter 6 of this Regulation.

Birthing Room. A room and environment designed and equipped to provide care, to accommodate support persons, and within which a woman with a low-risk, normal, full-term pregnancy can labor, deliver and recover with her infant.

Brace. An orthopedic appliance or apparatus (an orthosis) used to support, align, or hold parts of the body in correct position. For the purposes of CHAMPUS, it does not include orthodontic or other dental appliances.

Capped Rate. The maximum per diem or all-inclusive rate that CHAMPUS will allow for care.

Certified Nurse Midwife. An individual who meets the applicable requirements established by section C. of Chapter 6 of this Regulation.

Certified Psychiatric Nurse Specialist. A licensed, registered nurse who meets the criteria in Chapter 6, subparagraph C.3.c.(7).

CHAMPUS DRG-Based Payment System. A reimbursement system for hospitals which assigns prospectively-determined payment levels to each DRG based on the average cost of treating all CHAMPUS patients in a given DRG.

CHAMPUS Fiscal Intermediary. An organization with which the Director, OCHAMPUS, has entered into a contract for the adjudication and processing of CHAMPUS claims and the performance of related support activities.

CHAMPUS Health Benefits Advisors (HBAs). Those individuals located at Uniformed Services medical facilities (on occasion at other locations) and assigned the responsibility for providing CHAMPUS information, information concerning availability of care from the Uniformed Services direct medical care system, and generally assisting beneficiaries (or sponsors). The term also includes "Health Benefits Counselor" and "CHAMPUS Advisor."

Chemotherapy. The administration of approved antineoplastic drugs for the treatment of malignancies (cancer) via perfusion, infusion, or parenteral methods of administration.

Child. An unmarried legitimate child, adopted child, stepchild, or illegitimate child, who otherwise meets the requirements (including age requirements) set forth in paragraph B.2.d. of Chapter 3 of this Regulation.

Chiropractor. A practitioner of chiropractic (also called chiropraxis): essentially a system of therapeutics based upon the claim that disease is caused by abnormal function of the nerve system. It attempts to restore normal function of the nerve system by manipulation and treatment of the structures of the human body, especially those of the spinal column.

NOTE: Services of chiropractors are not covered by CHAMPUS.

Christian Science Nurse. An individual who has been accredited as a Christian Science Nurse by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts, and listed (or eligible to be listed) in the Christian Science Journal at the time the service is provided. The duties of Christian Science nurses are spiritual and are nonmedical and nontechnical nursing care performed under the direction of an accredited Christian Science practitioner. There exist two levels of Christian Science nurse accreditation:

1. Graduate Christian Science Nurse. This accreditation is granted by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts, after completion of a 3-year course of instruction and study.

2. Practical Christian Science Nurse. This accreditation is granted by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts, after completion of a 1-year course of instruction and study.

Christian Science Practitioner. An individual who has been accredited as a Christian Science Practitioner for the First Church of Christ, Scientist, Boston, Massachusetts, and listed (or eligible to be listed) in the Christian Science Journal at the time the service is provided. An individual who attains this accreditation has demonstrated results of his or her healing through faith and prayer rather than by medical treatment. Instruction is executed by an accredited Christian Science teacher and is continuous.

Christian Science Sanatorium. A sanatorium either operated by the First Church of Christ, Scientist, or listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts.

Chronic Medical Condition. A medical condition that is not curable, but which is under control through active medical treatment. Such chronic conditions may have periodic acute episodes and may require intermittent inpatient hospital care. However, a chronic medical condition can be controlled sufficiently to permit generally continuation of some activities of persons who are not ill (such as work and school).

Chronic Renal Disease (CRD). The end stage of renal disease which requires a continuing course of dialysis or a kidney transplantation to ameliorate uremic symptoms and maintain life.

Clinical Psychologist. A psychologist, certified or licensed at the independent practice level in his or her state, who meets the criteria in Chapter 6, subparagraph C.3.c.(1).

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Clinical Social Worker. An individual who is licensed or certified as a clinical social worker and meets the criteria listed in Chapter 6.

Collateral Visits. Sessions with the patient's family or significant others for purposes of information gathering or implementing treatment goals.

Combined Daily Charge. A billing procedure by an inpatient facility that uses an inclusive flat rate covering all professional and ancillary charges without any itemization.

Complications of Pregnancy. One of the following, when commencing or exacerbating during the term of the pregnancy:

1. Caesarean delivery; hysterotomy.
2. Pregnancy terminating before expiration of 26 weeks, except a voluntary abortion.
3. False labor or threatened miscarriage.
4. Nephritis or pyelitis of pregnancy.
5. Hyperemesis gravidarum.
6. Toxemia.
7. Aggravation of a heart condition or diabetes.
8. Premature rupture of membrane.
9. Ectopic pregnancy.
10. Hemorrhage.
11. Other conditions as may be determined by the Director, OCHAMPUS, or a designee.

Confinement. That period of time from the day of admission to a hospital or other institutional provider, to the day of discharge, transfer, or separation from the facility, or death. Successive admissions also may qualify as one confinement provided not more than 60 days have elapsed between the successive admissions, except that successive admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions.

Conflict of Interest. Includes any situation where an active duty member (including a reserve member while on active duty) or civilian employee of the United States Government, through an official federal position, has the apparent or actual opportunity to exert, directly or indirectly, any influence on the referral of CHAMPUS beneficiaries to himself or herself or others with some potential for personal gain or appearance of impropriety. For purposes of this Regulation, individuals under contract to a Uniformed Service may be involved in a conflict of interest situation through the contract position.

Congenital Anomaly. A condition existing at or from birth that is a significant deviation from the common form or norm and is other than a common racial or ethnic feature. For purposes of CHAMPUS, congenital anomalies do not include anomalies relating to teeth (including malocclusion or missing tooth buds) or structures supporting the teeth, or to any form of hermaphroditism or sex gender confusion. Examples of congenital anomalies are harelip, birthmarks, webbed fingers or toes, or such other conditions that the Director, OCHAMPUS, or a designee, may determine to be congenital anomalies.

NOTE: Also refer to subsection E.7. of Chapter 4 of this Regulation.

Consultation. A deliberation with a specialist physician or dentist requested by the attending physician primarily responsible for the medical care of the patient, with respect to the diagnosis or treatment in any particular case. A consulting physician or dentist may perform a limited examination of a given system or one requiring a complete diagnostic history and examination. To qualify as a consultation, a written report to the attending physician of the findings of the consultant is required.

NOTE: Staff consultations required by rules and regulations of the medical staff of a hospital or other institutional provider do not qualify as consultation.

Consulting Physician or Dentist. A physician or dentist, other than the attending physician, who performs a consultation.

Conviction. For purposes of this Regulation, "conviction" or "convicted" means that (1) a judgment of conviction has been entered, or (2) there has been a finding of guilt by the trier of fact, or (3) a plea of guilty or a plea of nolo contendere has been accepted by a court of competent jurisdiction, regardless of whether an appeal is pending.

Coordination of Benefits. The coordination, on a primary or secondary payer basis, of the payment of benefits between two or more health care coverages to avoid duplication of benefit payments.

Cosmetic, Reconstructive, or Plastic Surgery. Surgery that can be expected primarily to improve the physical appearance of a beneficiary, or that is performed primarily for psychological purposes, or that restores form, but does not correct or improve materially a bodily function.

Cost-Share. The amount of money for which the beneficiary (or sponsor) is responsible in connection with otherwise covered inpatient and outpatient services (other than the annual fiscal year deductible or disallowed amounts) as set forth in section F. of Chapter 4, and section B. of Chapter 5 of this Regulation. Cost-sharing may also be referred to as "co-payment."

Custodial Care. Care rendered to a patient (1) who is disabled mentally or physically and such disability is expected to continue and be prolonged, and (2) who requires a protected, monitored, or controlled environment whether in an institution or in the home, and (3) who requires assistance to support the essentials of daily living, and (4) who is not under active and

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specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment. A custodial care determination is not precluded by the fact that a patient is under the care of a supervising or attending physician and that services are being ordered and prescribed to support and generally maintain the patient's condition, or provide for the patient's comfort, or ensure the manageability of the patient. Further, a custodial care determination is not precluded because the ordered and prescribed services and supplies are being provided by an R.N., L.P.N., or L.V.N.

NOTE: The determination of custodial care in no way implies that the care being rendered is not required by the patient; it only means that it is the kind of care that is not covered under CHAMPUS. A program of physical and mental rehabilitation which is designed to reduce a disability is not custodial care as long as the objective of the program is a reduced level of care.

Day or Night Care. A program of services for the diagnosis, care, and treatment of persons with psychiatric disorders that provides a planned medical therapeutic program for patients who do not require full-time hospitalization but who need broader programs than are possible through outpatient visits. Patients may participate in such programs on a day or night basis but not both programs (to do so would constitute inpatient psychiatric hospitalization). Such programs must vest patient care under the supervision of a professional staff of licensed physicians. Such programs also must be operated under the auspices, either by contract or direct administration, of a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or a community mental health center.

NOTE: The term "Day or Night Center" is frequently used inappropriately to connote a single free-standing facility. This term is synonymous with the term "Partial Hospitalization."

Days. Calendar days.

Deceased Service Member. A person who, at the time of his or her death, was an active duty member of a Uniformed Service under a call or order that did not specify a period of 30 days or less; or a retiree of a Uniformed Service.

Deductible. Payment by a beneficiary of the first \$50 of the CHAMPUS-determined allowable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year; or for a family, the aggregate payment by two or more beneficiaries who submit claims of the first \$100.

Deductible Certificate. A statement issued to the beneficiary (or sponsor) by a CHAMPUS fiscal intermediary certifying to deductible amounts satisfied by a CHAMPUS beneficiary for any applicable fiscal year.

Defense Enrollment Eligibility Reporting System (DEERS). The automated system that is composed of two phases:

1. Enrolling all active duty and retired service members, their dependents, and the dependents of deceased service members, and
2. Verifying their eligibility for health care benefits in the direct care facilities and through CHAMPUS.

Dental Care. Services relating to the teeth and their supporting structures.

Dentist. Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery (D.D.S.) who is licensed to practice dentistry by an appropriate authority.

Dependent. A person who bears any of the following relationships to an active duty member (under a call or order that does not specify a period of 30 days or less), retiree, or deceased active duty member or retiree, of a Uniformed Service, that is, lawful spouse, former spouse (in certain circumstances), unremarried widow or widower, or child; or a spouse and child of an active duty member of the armed forces of foreign North Atlantic Treaty Organization (NATO) nations (refer to section B. in Chapter 3 of this Regulation).

Deserter or Desertion Status. A service member is a deserter, or in a desertion status, when the Uniformed Service concerned has made an administrative determination to that effect, or the member's period of unauthorized absence has resulted in a court-martial conviction of desertion. Administrative declarations of desertion normally are made when a member has been an unauthorized absentee for over 30 days, but particular circumstances may result in an earlier declaration. Entitlement to CHAMPUS benefits ceases as of 12:01 a.m. on the day following the day the desertion status is declared. Benefits are not to be authorized for treatment received during a period of unauthorized absence that results in a court-martial conviction for desertion. Dependent eligibility for benefits is reestablished when a deserter is returned to military control and continues, even though the member may be in confinement, until any discharge is executed. When a deserter status is later found to have been determined erroneously, the status of deserter is considered never to have existed, and the member's dependents will have been eligible continuously for benefits under CHAMPUS.

Diagnosis-Related Groups (DRGs). Diagnosis-related groups (DRGs) are a method of dividing hospital patients into clinically coherent groups based on the consumption of resources. Patients are assigned to the groups based on their principal diagnosis (the reason for admission, determined after study), secondary diagnoses, procedures performed, and the patient's age, sex, and discharge status.

Diagnostic Admission. An admission to a hospital or other authorized institutional provider, or an extension of a stay in such a facility, primarily for the purpose of performing diagnostic tests, examinations, and procedures.

Doctor of Dental Medicine (D.M.D.). A person who has received a degree in dentistry, that is, that department of the healing arts which is concerned with the teeth, oral cavity, and associated structures.

Doctor of Medicine (M.D.). A person who has graduated from a college of allopathic medicine and who is entitled legally to use the designation M.D.

Doctor of Osteopathy (D.O.). A practitioner of osteopathy, that is, a system of therapy based on the theory that the body is capable of making its own remedies against disease and other toxic conditions when it is in normal structural relationship and has favorable environmental conditions and adequate nutrition. It utilizes generally accepted physical, medicinal, and surgical methods of diagnosis and therapy, while placing chief emphasis on the importance of normal body mechanics and manipulative methods of detecting and correcting faulty structure.

Domiciliary Care. Inpatient institutional care provided the beneficiary not because it is medically necessary, but because the care in the home setting is not available, is unsuitable, or members of the patient's family are unwilling to provide the care. Institutionalization because of abandonment constitutes domiciliary care.

NOTE: The terms "domiciliary" and "custodial care" represent separate concepts and are not interchangeable. Domiciliary care is not covered under either the CHAMPUS Basic Program or the Program for the Handicapped (PFTH).

Donor. An individual who supplies living tissue or material to be used in another body, such as a person who furnishes a kidney for renal transplant.

Double Coverage. When a CHAMPUS beneficiary also is enrolled in another insurance, medical service, or health plan that duplicates all or part of a beneficiary's CHAMPUS benefits.

Double Coverage Plan. The specific insurance, medical service, or health plan under which a CHAMPUS beneficiary has entitlement to medical benefits that duplicate CHAMPUS benefits in whole or in part. Double coverage plans do not include:

1. Medicaid.
2. Coverage specifically designed to supplement CHAMPUS benefits.
3. Entitlement to receive care from the Uniformed Services medical facilities; or
4. Entitlement to receive care from Veterans Administration medical care facilities.

Dual Compensation. Federal Law (5 U.S.C. 5536) prohibits active duty members or civilian employees of the United States Government from receiving additional compensation from the government above their normal pay and allowances. This prohibition applies to CHAMPUS cost-sharing of medical care provided by active duty members or civilian government employees to CHAMPUS beneficiaries.

Durable Medical Equipment. Equipment for which the allowable charge is over \$100 and which:

1. Is medically necessary for the treatment of a covered illness or injury;
2. Improves the function of a malformed, diseased, or injured body part, or retards further deterioration of a patient's physical condition;
3. Is used primarily and customarily to serve a medical purpose rather than primarily for transportation, comfort, or convenience;
4. Can withstand repeated use;
5. Provides the medically appropriate level of performance and quality for the medical condition present (that is, nonluxury and nondeluxe);
6. Is other than spectacles, eyeglasses, contact lenses, or other optical devices, hearing aids, or other communication devices; and
7. Is other than exercise equipment, spas, whirlpools, hot tubs, swimming pools or other such items.

Emergency Inpatient Admission. An unscheduled, unexpected, medically necessary admission to a hospital or other authorized institutional provider for treatment of a medical condition meeting the definition of medical emergency and which is determined to require immediate inpatient treatment by the attending physician.

Entity. For purposes of Chapter 9.F.1., "entity" includes a corporation, trust, partnership, sole proprietorship or other kind of business enterprise that is or may be eligible to receive reimbursement either directly or indirectly from CHAMPUS.

Essentials of Daily Living. Care that consists of providing food (including special diets), clothing, and shelter; personal hygiene services; observation and general monitoring; bowel training or management; safety precautions; general preventive procedures (such as turning to prevent bedsores); passive exercise; companionship; recreation; transportation; and such other elements of personal care that reasonably can be performed by an untrained adult with minimal instruction or supervision.

Experimental. Medical care that essentially is investigatory or an unproven procedure or treatment regimen (usually performed under controlled medicolegal conditions) that does not meet the generally accepted standards of usual professional medical practice in the general medical community. The conduct of biomedical or behavioral research involving human subjects at risk to physical, psychological, or social injury is experimental medicine. For the purposes of CHAMPUS, any medical services or supplies provided under a scientific research grant, either public or private, are classified as "experimental." (Financial grants-in-aid to an individual beneficiary are not considered grants for this purpose.) Use of drugs and medicines and devices not approved by the Food and Drug Administration for general use by humans (even though approved for testing on human beings) also is considered experimental. However, if a drug or medicine is listed in the U.S. Pharmacopeia or the National Formulary and requires a prescription, it is not

considered experimental even if it is under investigation by the U.S. Food and Drug Administration as to its effectiveness. NOTE: In areas outside the United States, standards comparable to those of the U.S. Food and Drug Administration is the CHAMPUS objective.

External Partnership Agreement. The external partnership agreement is an agreement between a military treatment facility commander and a CHAMPUS authorized institutional provider, enabling Uniformed Services health care personnel to provide otherwise covered medical care to CHAMPUS beneficiaries in a civilian facility under the Military-Civilian Health Services Partnership Program. Authorized costs associated with the use of the facility will be financed through CHAMPUS under normal cost-sharing and reimbursement procedures currently applicable under the basic CHAMPUS.

Extramedical Individual Providers of Care. Individuals who do counseling or nonmedical therapy and whose training and therapeutic concepts are outside the medical field, as specified in Chapter 6 of this Regulation.

Fraud. For purposes of this Regulation, fraud is defined as 1) a deception or misrepresentation by a provider, beneficiary, sponsor, or any person acting on behalf of a provider, sponsor, or beneficiary with the knowledge (or who had reason to know or should have known) that the deception or misrepresentation could result in some unauthorized CHAMPUS benefit to self or some other person, or some unauthorized CHAMPUS payment, or 2) a claim that is false or fictitious, or includes or is supported by any written statement which asserts a material fact which is false or fictitious, or includes or is supported by any written statement that (a) omits a material fact and (b) is false or fictitious as a result of such omission and (c) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact. It is presumed that, if a deception or misrepresentation is established and a CHAMPUS claim is filed, the person responsible for the claim had the requisite knowledge. This presumption is rebuttable only by substantial evidence. It is further presumed that the provider of the services is responsible for the actions of all individuals who file a claim on behalf of the provider (for example, billing clerks); this presumption may only be rebutted by clear and convincing evidence.

Freestanding. Not "institution-affiliated" or "institution-based."

Former Spouse. A former husband or wife of a Uniformed Service member or former member who meets the criteria as set forth in paragraph B.2.b. of Chapter 3 of this Regulation.

Full-Time Course of Higher Education. A complete, progressive series of studies to develop attributes such as knowledge, skill, mind, and character, by formal schooling at a college or university, and which meets the criteria set out in Chapter 3 of this Regulation. To qualify as full-time, the student must be carrying a course load of a minimum of 12 credit hours or equivalent each semester.

General Staff Nursing Service. All nursing care (other than that provided by private duty nurses) including, but not limited to, general duty

nursing, emergency room nursing, recovery room nursing, intensive nursing care, and group nursing arrangements performed by nursing personnel on the payroll of the hospital or other authorized institution.

Good Faith Payments. Those payments made to civilian sources of medical care who provided medical care to persons purporting to be eligible beneficiaries but who are determined later to be ineligible for CHAMPUS benefits. (The ineligible person usually possesses an erroneous or illegal identification card.) To be considered for good faith payments, the civilian source of care must have exercised reasonable precautions in identifying a person claiming to be an eligible beneficiary.

High-risk pregnancy. A pregnancy is high-risk when the presence of a currently active or previously treated medical, anatomical, physiological illness or condition may create or increase the likelihood of a detrimental effect on the mother, fetus, or newborn and presents a reasonable possibility of the development of complications during labor or delivery.

Hospital, Acute Care (General and Special). An institution that meets the criteria as set forth in paragraph B.4.a. of Chapter 6 of this Regulation.

Hospital, Long-Term (Tuberculosis, Chronic Care, or Rehabilitation). An institution that meets the criteria as set forth in paragraph B.4. of Chapter 6 of this Regulation.

Hospital, Psychiatric. An institution that meets the criteria as set forth in paragraph B.4. of Chapter 6 of this Regulation.

Illegitimate Child. A child not recognized as a lawful offspring; that is, a child born of parents not married to each other.

Immediate Family. The spouse, natural parent, child and sibling, adopted child and adoptive parent, stepparent, stepchild, grandparent, grandchild, stepbrother and stepsister, father-in-law, mother-in-law of the beneficiary, or provider, as appropriate. For purposes of this definition only, to determine who may render services to a beneficiary, the step-relationship continues to exist even if the marriage upon which the relationship is based terminates through divorce or death of one of the parents.

Independent Laboratory. A freestanding laboratory approved for participation under Medicare and certified by the Health Care Financing Administration.

Infirmaries. Facilities operated by student health departments of colleges and universities to provide inpatient or outpatient care to enrolled students. When specifically approved by the Director, OCHAMPUS, or a designee, a boarding school infirmary also is included.

Initial Determination. A formal written decision on a CHAMPUS claim, a request for benefit authorization, a request by a provider for approval as an authorized CHAMPUS provider, or a decision disqualifying or excluding a provider as an authorized provider under CHAMPUS. Rejection of a claim or a

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request for benefit or provider authorization for failure to comply with administrative requirements, including failure to submit reasonably requested information, is not an initial determination. Responses to general or specific inquiries regarding CHAMPUS benefits are not initial determinations.

In-Out Surgery. Surgery performed in the outpatient department of a hospital or other institutional provider, in a physician's office or the office of another individual professional provider, in a clinic, or in a "freestanding" ambulatory surgical center which does not involve a formal inpatient admission for a period of 24 hours or more.

Inpatient. A patient who has been admitted to a hospital or other authorized institution for bed occupancy for purposes of receiving necessary medical care, with the reasonable expectation that the patient will remain in the institution at least 24 hours, and with the registration and assignment of an inpatient number or designation. Institutional care in connection with in and out (ambulatory) surgery is not included within the meaning of inpatient whether or not an inpatient number or designation is made by the hospital or other institution. If the patient has been received at the hospital, but death occurs before the actual admission occurs, an inpatient admission exists as if the patient had lived and had been formally admitted.

Institution-Affiliated. Related to a CHAMPUS authorized institutional provider through a shared governing body but operating under a separate and distinct license or accreditation.

Institution-Based. Related to a CHAMPUS authorized institutional provider through a shared governing body and operating under a common license and shared accreditation.

Institutional Provider. A health care provider which meets the applicable requirements established by section B. of Chapter 6 of this Regulation.

Intensive Care Unit (ICU). A special segregated unit of a hospital in which patients are concentrated by reason of serious illness, usually without regard to diagnosis. Special lifesaving techniques and equipment regularly and immediately are available within the unit, and patients are under continuous observation by a nursing staff specially trained and selected for the care of this type patient. The unit is maintained on a continuing rather than an intermittent or temporary basis. It is not a postoperative recovery room nor a postanesthesia room. In some large or highly specialized hospitals, the ICUs may be further refined for special purposes, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery. For the purposes of CHAMPUS, these specialized units would be considered ICUs if they otherwise conformed to the definition of an ICU.

Intern. A graduate of a medical or dental school serving in a hospital in preparation to being licensed to practice medicine or dentistry.

Internal Partnership Agreement. The internal partnership agreement is an agreement between a military treatment facility commander and a CHAMPUS authorized civilian health care provider which enables the use of civilian

health care personnel or other resources to provide medical care to CHAMPUS beneficiaries on the premises of a military treatment facility under the Military-Civilian Health Services Partnership Program. These internal agreements may be established when a military treatment facility is unable to provide sufficient health care services for CHAMPUS beneficiaries due to shortages of personnel and other required resources.

Item, Service, or Supply. Includes (1) any item, device, medical supply, or service claimed to have been provided to a beneficiary (patient) and listed in an itemized claim for CHAMPUS payment or a request for payment, or (2) in the case of a claim based on costs, any entry or omission in a cost report, books of account, or other documents supporting the claim.

Laboratory and Pathological Services. Laboratory and pathological examinations (including machine diagnostic tests that produce hard-copy results) when necessary to, and rendered in connection with medical, obstetrical, or surgical diagnosis or treatment of an illness or injury, or in connection with well-baby care.

Legitimized Child. A formerly illegitimate child who is considered legitimate by reason of qualifying actions recognized in law.

Licensed Practical Nurse (L.P.N.). A person who is prepared specially in the scientific basis of nursing; who is a graduate of a school of practical nursing; whose qualifications have been examined by a state board of nursing; and who has been authorized legally to practice as an L.P.N. under the supervision of a physician.

Licensed Vocational Nurse (L.V.N.). A person who specifically is prepared in the scientific basis of nursing; who is a graduate of a school of vocational nursing; whose qualifications have been examined by a state board of nursing; and who has been authorized legally to practice as a L.V.N. under the supervision of a physician.

Long-Term Hospital Care. Any inpatient hospital stay that exceeds 30 days.

Low-Risk Pregnancy. A pregnancy is low-risk when the basis for the ongoing clinical expectation of a normal uncomplicated birth, as defined by reasonable and generally accepted criteria of maternal and fetal health, is documented throughout a generally accepted course of prenatal care.

Management Plan. A detailed description of the medical history of and proposed therapy for a CHAMPUS beneficiary seeking benefits under the PFTH as set forth in Chapter 5 of this Regulation. A management plan must include, at a minimum, a diagnosis (either in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) or the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III)); detailed reports of prior treatment, family history, social history, history of handicapping condition, and physical examination; diagnostic test results; consultants (if any) reports; proposed therapeutic approach and modality (including anticipated length of time the proposed modality will be

required); prognosis; problem list; and all inclusive current or anticipated monthly charges related to the proposed management plan. If the management plan involves the transfer of a beneficiary from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the management plan documentation.

Marriage and Family Counselor or Pastoral Counselor. A person who has completed a recognized graduate professional education with the minimum of an earned master's degree from an accredited educational institution in an appropriate behavioral science field or mental health discipline and meets the experience requirements set forth in Chapter 6 of this Regulation.

Maternity Care. Care and treatment related to conception, delivery, and abortion, including prenatal and postnatal care (generally through the 6th post-delivery week), and also including treatment of the complications of pregnancy.

Medicaid. Those medical benefits authorized under Title XIX of the Social Security Act (reference (h)) provided to welfare recipients and the medically indigent through programs administered by the various states.

Medical. The generally used term which pertains to the diagnosis and treatment of illness, injury, pregnancy, and mental disorders by trained and licensed or certified health professionals. For purposes of CHAMPUS, the term "medical" should be understood to include "medical, psychological, surgical, and obstetrical," unless it is specifically stated that a more restrictive meaning is intended.

Medical Emergency. The sudden and unexpected onset of a medical condition or the acute exacerbation of a chronic condition that is threatening to life, limb, or sight, and requires immediate medical treatment or which manifests painful symptomatology requiring immediate palliative efforts to alleviate suffering. Medical emergencies include heart attacks, cardiovascular accidents, poisoning, convulsions, kidney stones, and such other acute medical conditions as may be determined to be medical emergencies by the Director, OCHAMPUS, or a designee. In the case of a pregnancy, a medical emergency must involve a sudden and unexpected medical complication that puts the mother, the baby, or both, at risk. Pain would not, however, qualify a maternity case as an emergency, nor would incipient birth after the 34th week of gestation, unless an otherwise qualifying medical condition is present. Examples of medical emergencies related to pregnancy or delivery are hemorrhage, ruptured membrane with prolapsed cord, placenta previa, abruptio placenta, presence of shock or unconsciousness, suspected heart attack or stroke, or trauma (such as injuries received in an automobile accident).

Medically or Psychologically Necessary. The frequency, extent, and types of medical services or supplies which represent appropriate medical care and that are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, and mental disorders or that are reasonable and adequate for well-baby care.

Medical Supplies and Dressings (Consumables). Necessary medical or surgical supplies (exclusive of durable medical equipment) that do not withstand prolonged, repeated use and that are needed for the proper medical management of a condition for which benefits are otherwise authorized under CHAMPUS, on either an inpatient or outpatient basis. Examples include disposable syringes for a diabetic, colostomy sets, irrigation sets, and ace bandages.

Medicare. Those medical benefits authorized under Title XVIII of the Social Security Act (reference (h)) provided to persons 65 or older, certain disabled persons, or persons with chronic renal disease, through a national program administered by the DHHS, Health Care Financing Administration, Medicare Bureau.

Mental Disorder. For purposes of the payment of CHAMPUS benefits, a mental disorder is a nervous or mental condition that involves a clinically significant behavioral or psychological syndrome or pattern that is associated with a painful symptom, such as distress, and that impairs a patient's ability to function in one or more major life activities. Additionally, the mental disorder must be one of those conditions listed in the DSM-III.

Mental Health Counselor. An individual who meets the requirements established by paragraph C.3.d. of chapter 6 of this Regulation.

Mental Health Therapeutic Absence. A therapeutically planned absence from the inpatient setting. The patient is not discharged from the facility and may be away for periods of several hours to several days. The purpose of the therapeutic absence is to give the patient an opportunity to test his or her ability to function outside the inpatient setting before the actual discharge.

Mental Retardation. Subnormal general intellectual functioning associated with impairment of either learning and social adjustment or maturation, or both. The diagnostic classification of moderate and severe mental retardation relates to intelligence quotient (IQ) as follows:

1. Moderate. Moderate mental retardation IQ 36-51.
2. Severe. Severe mental retardation IQ 35 and under.

Missing in Action (MIA). A battle casualty whose whereabouts and status are unknown, provided the absence appears to be involuntary and the service member is not known to be in a status of unauthorized absence. NOTE: Claims for eligible CHAMPUS beneficiaries whose sponsor is classified as MIA are processed as dependents of an active duty service member.

Morbid Obesity. The body weight is 100 pounds over ideal weight for height and bone structure, according to the most current Metropolitan Life Table, and such weight is in association with severe medical conditions known to have higher mortality rates in association with morbid obesity; or, the

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body weight is 200 percent or more of the ideal weight for height and bone structure according to the most current Metropolitan Life Table. The associated medical conditions are diabetes mellitus, hypertension, cholecystitis, narcolepsy, pickwickian syndrome (and other severe respiratory diseases), hypothalamic disorders, and severe arthritis of the weight-bearing joints.

Most-Favored Rate. The lowest usual charge to any individual or third-party payer in effect on the date of the admission of a CHAMPUS beneficiary.

Natural Childbirth. Childbirth without the use of chemical induction or augmentation of labor or surgical procedures other than episiotomy or perineal repair.

Naturopath. A person who practices naturopathy, that is, a drugless system of therapy making use of physical forces such as air, light, water, heat, and massage. NOTE: Services of a naturopath are not covered by CHAMPUS.

Nonavailability Statement. A certification by a commander (or a designee) of a Uniformed Services medical treatment facility recorded on DD Form 1251, generally for the reason that the needed medical care being requested by a CHAMPUS beneficiary cannot be provided at the facility concerned because the necessary resources are not available.

Nonparticipating Provider. A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished medical services or supplies to a CHAMPUS beneficiary, but who did not agree on the CHAMPUS claim form to participate or to accept the CHAMPUS-determined allowable cost or charge as the total charge for the services. A nonparticipating provider looks to the beneficiary or sponsor for payment of his or her charge, not CHAMPUS. In such cases, CHAMPUS pays the beneficiary or sponsor, not the provider.

North Atlantic Treaty Organization (NATO) Member. A military member of an armed force of a foreign NATO nation who is on active duty and who, in connection with official duties, is stationed in or passing through the United States. The foreign NATO nations are Belgium, Canada, Denmark, France, Federal Republic of Germany, Greece, Iceland, Italy, Luxemburg, the Netherlands, Norway, Portugal, Spain, Turkey, and the United Kingdom.

Official Formularies. A book of official standards for certain pharmaceuticals and preparations that are not included in the U.S. Pharmacopeia.

Optometrist (Doctor of Optometry). A person trained and licensed to examine and test the eyes and to treat visual defects by prescribing and adapting corrective lenses and other optical aids, and by establishing programs of exercises.

Oral Surgeon (D.D.S. or D.M.D.). A person who has received a degree in dentistry and who limits his or her practice to oral surgery, that is, that branch of the healing arts that deals with the diagnosis and the surgical correction and adjunctive treatment of diseases, injuries, and defects of the mouth, the jaws, and associated structures.

Orthopedic Shoes. Shoes prescribed by an orthopedic surgeon to effect changes in foot or feet position and alignment and which are not an integral part of a brace.

Other Allied Health Professionals. Individual professional providers other than physicians, dentists, or extramedical individual providers, as specified in Chapter 6 of this Regulation.

Other Specialized Treatment Facilities (STFs). Certain specialized medical treatment facilities, either inpatient or outpatient, other than those specifically defined, that provide courses of treatment prescribed by a doctor of medicine or osteopathy; when the patient is under the supervision of a doctor of medicine or osteopathy during the entire course of the inpatient admission or the outpatient treatment; when the type and level of care and services rendered by the institution are otherwise authorized in this Regulation; when the facility meets all licensing or other certification requirements that are extant in the jurisdiction in which the facility is located geographically; which is accredited by the Joint Commission on Accreditation if an appropriate accreditation program for the given type of facility is available; and which is not a nursing home, intermediate facility, halfway house, home for the aged, or other institution of similar purpose.

Outpatient. A patient who has not been admitted to a hospital or other authorized institution as an inpatient.

Ownership or Control Interest. For purposes of Chapter 9.F.1., a "person with an ownership or control interest" is anyone who

1. Has directly or indirectly a 5 percent or more ownership interest in the entity; or
2. Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 percent of the total property and assets of the entity; or
3. Is an officer or director of the entity if the entity is organized as a corporation; or
4. Is a partner in the entity if the entity is organized as a partnership.

Participating Provider. A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished services or supplies to a CHAMPUS beneficiary and that has agreed, by act of signing and submitting a CHAMPUS claim form and indicating participation in the appropriate space on the claim form, to accept the CHAMPUS-determined allowable cost or charge as the total charge (even though less than the actual billed amount), whether paid for fully by the CHAMPUS allowance or requiring cost-sharing by the beneficiary (or sponsor).

Party to a Hearing. An appealing party or parties and CHAMPUS.

Party to the Initial Determination. Includes CHAMPUS and also refers to a CHAMPUS beneficiary and a participating provider of services whose interests have been adjudicated by the initial determination. In addition, a provider who has been denied approval as an authorized CHAMPUS provider is a party to that initial determination, as is a provider who is disqualified or excluded as an authorized provider under CHAMPUS, unless the provider is excluded based on a determination of abuse or fraudulent practices or procedures under another federal or federally funded program. See Chapter 10 for additional information concerning parties not entitled to administrative review under the CHAMPUS appeals and hearing procedures.

Pharmacist. A person who is trained specially in the scientific basis of pharmacology and who is licensed to prepare and sell or dispense drugs and compounds and to make up prescriptions ordered by a physician.

Physical Medicine Services or Physiatry Services. The treatment of disease or injury by physical means such as massage, hydrotherapy, or heat.

Physical Handicap. A physical condition of the body that meets the following criteria:

1. Duration. The condition is expected to result in death, or has lasted, or with reasonable certainty is expected to last, for a minimum period of 12 months; and
2. Extent. The condition is of such severity as to preclude the individual from engaging in substantially basic productive activities of daily living expected of unimpaired persons of the same age group.

Physical Therapist. A person who is trained specially in the skills and techniques of physical therapy (that is, the treatment of disease by physical agents and methods such as heat, massage, manipulation, therapeutic exercise, hydrotherapy, and various forms of energy such as electrotherapy and ultrasound), who has been authorized legally (that is, registered) to administer treatments prescribed by a physician and who is entitled legally to use the designation "Registered Physical Therapist." A physical therapist also may be called a physiotherapist.

Physician. A person with a degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is licensed to practice medicine by an appropriate authority.

Podiatrist (Doctor of Podiatry or Surgical Chiropody). A person who has received a degree in podiatry (formerly called chiropody), that is, that specialized field of the healing arts that deals with the study and care of the foot, including its anatomy, pathology, and medical and surgical treatment.

Preauthorization. A decision issued in writing by the Director, OCHAMPUS, or a designee, that CHAMPUS benefits are payable for certain services that a beneficiary has not yet received.

Prescription Drugs and Medicines. Drugs and medicines which at the time of use were approved for general use by humans by the U.S. Food and Drug Administration as listed in the U.S. Pharmacopeia and National Formulary, were available commercially, and which, by law of the United States, require a physician's or dentist's prescription, except that it includes insulin for known diabetics whether or not a prescription is required.

NOTE: The fact that the U.S. Food and Drug Administration has approved a drug for testing on humans would not qualify it within this definition.

Preventive Care. Diagnostic and other medical procedures not related directly to a specific illness, injury, or definitive set of symptoms, or obstetrical care, but rather performed as periodic health screening, health assessment, or health maintenance.

Primary Payer. The plan or program whose medical benefits are payable first in a double coverage situation.

Private Duty (Special) Nursing Services. Skilled nursing services rendered to an individual patient requiring intensive medical care. Such private duty (special) nursing must be by an actively practicing registered nurse (R.N.) or licensed practical or vocational nurse (L.P.N. or L.V.N.) only when the medical condition of the patient requires intensive skilled nursing services (rather than primarily providing the essentials of daily living) and when such skilled nursing care is ordered by the attending physician.

Private Room. A room with one bed that is designated as a private room by the hospital or other authorized institutional provider.

Program for the Handicapped (PFTH). The special program set forth in Chapter 5 of this Regulation, through which dependents of active duty members receive supplemental benefits for the moderately or severely mentally retarded and the seriously physically handicapped over and above those medical benefits available under the Basic Program.

Prosthetic Device (Prosthesis). An artificial substitute for a missing body part.

Provider. A hospital or other institutional provider, a physician, or other individual professional provider, or other provider of services or supplies as specified in Chapter 6 of this Regulation.

Provider Exclusion and Suspension. The terms "exclusion" and "suspension", when referring to a provider under CHAMPUS, both mean the denial of status as an authorized provider, resulting in items, services, or supplies furnished by the provider not being reimbursed, directly or indirectly, under CHAMPUS. The terms may be used interchangeably to refer to a provider who has been denied status as an authorized CHAMPUS provider based on 1) a criminal conviction or civil judgment involving fraud, 2) an administrative finding of fraud or abuse under CHAMPUS, 3) an administrative finding that the provider has been excluded or suspended by another agency of the Federal Government, a state, or a local licensing authority, 4) an administrative finding that the provider has knowingly participated in a conflict of interest situation, or 5) an administrative finding that it is in the best interests of the CHAMPUS or CHAMPUS beneficiaries to exclude or suspend the provider.

Provider Termination. When a provider's status as an authorized CHAMPUS provider is ended, other than through exclusion or suspension, based on a finding that the provider does not meet the qualifications, as set forth in Chapter 6 of this Regulation, to be an authorized CHAMPUS provider.

Radiation Therapy Services. The treatment of diseases by x-ray, radium, or radioactive isotopes when ordered by the attending physician.

Referral. The act or an instance of referring a CHAMPUS beneficiary to another authorized provider to obtain necessary medical treatment. Under CHAMPUS, only a physician may make referrals.

Registered Nurse. A person who is prepared specially in the scientific basis of nursing, who is a graduate of a school of nursing, and who is registered for practice after examination by a state board of nurse examiners or similar regulatory authority, who holds a current, valid license, and who is entitled legally to use the designation R.N.

Representative. Any person who has been appointed by a party to the initial determination as counsel or advisor and who is otherwise eligible to serve as the counsel or advisor of the party to the initial determination, particularly in connection with a hearing.

Resident (Medical). A graduate physician or dentist who has an M.D. or D.O. degree, or D.D.S. or D.M.D. degree, respectively, is licensed to practice, and who chooses to remain on the house staff of a hospital to get further training that will qualify him or her for a medical or dental specialty.

Residential Treatment Center (RTC). A facility (or distinct part of a facility) which meets the criteria in Chapter 6.B.4.

Retiree. A member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay based on duty in a Uniformed Service.

Routine Eye Examinations. The services rendered in order to determine the retractive state of the eyes.

Sanction. For purpose of Chapter 9, "sanction" means a provider exclusion, suspension, or termination.

Secondary Payer. The plan or program whose medical benefits are payable in double coverage situations only after the primary payer has adjudicated the claim.

Semiprivate Room. A room containing at least two beds. If a room is designated publicly as a semiprivate accommodation by the hospital or other authorized institutional provider and contains multiple beds, it qualifies as a semiprivate room for the purposes of CHAMPUS.

Skilled Nursing Facility. An institution (or a distinct part of an institution) that meets the criteria as set forth in subsection B.4. of Chapter 6 of this Regulation.

Skilled Nursing Service. A service that can only be furnished by an R.N., or L.P.N. or L.V.N., and is required to be performed under the supervision of a physician to ensure the safety of the patient and achieve the medically desired result. Examples of skilled nursing services are intravenous or intramuscular injections, levin tube or gastrostomy feedings, or tracheotomy aspiration and insertion. Skilled nursing services are other than those services that provide primarily support for the essentials of daily living or that could be performed by an untrained adult with minimum instruction or supervision.

Special Tutoring. Teaching or instruction provided by a private teacher to an individual usually in a private or separate setting to enhance the educational development of an individual in one or more study areas.

Spectacles, Eyeglasses, and Lenses. Lenses, including contact lenses, that help to correct faulty vision.

Sponsor. An active duty member, retiree, or deceased active duty member or retiree, of a Uniformed Service upon whose status his or her dependents' eligibility for CHAMPUS is based.

Spouse. A lawful wife or husband regardless of whether or not dependent upon the active duty member or retiree.

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Student Status. A dependent of a member or former member of a Uniformed Service who has not passed his or her 23rd birthday, and is enrolled in a full-time course of study in an institution of higher learning.

Suppliers of Portable X-Ray Services. A supplier that meets the conditions of coverage of the Medicare program, set forth in the Medicare regulations (reference (m)), or the Medicaid program in the state in which the covered service is provided.

Surgery. Medically appropriate operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and those certain procedures listed in paragraph C.2.a. of Chapter 4 of this Regulation.

Surgical Assistant. A physician (or dentist or podiatrist) who assists the operating surgeon in the performance of a covered surgical service when such assistance is certified as necessary by the attending surgeon, when the type of surgical procedure being performed is of such complexity and seriousness as to require a surgical assistant, and when interns, residents, or other house staff are not available to provide the surgical assistance services in the specialty area required.

Suspension of Claims Processing. The temporary suspension of processing (to protect the government's interests) of claims for care furnished by a specific provider (whether the claims are submitted by the provider or beneficiary) or claims submitted by or on behalf of a specific CHAMPUS beneficiary pending action by the Director, OCHAMPUS, or a designee, in a case of suspected fraud or abuse. The action may include the administrative remedies provided for in Chapter 9 or any other Department of Defense issuance (e.g. DoD issuances implementing the Program Fraud Civil Remedies Act), case development or investigation by OCHAMPUS, or referral to the Department of Defense-Inspector General or the Department of Justice for action within their cognizant jurisdictions.

Timely Filing. The filing of CHAMPUS claims within the prescribed time limits as set forth in Chapter 7 of this Regulation.

Treatment Plan. A detailed description of the medical care being rendered or expected to be rendered a CHAMPUS beneficiary seeking approval for inpatient benefits for which preauthorization is required as set forth in section B. of Chapter 4 of this Regulation. A treatment plan must include, at a minimum, a diagnosis (either ICD-9-CM or DSM-III); detailed reports of prior treatment, medical history, family history, social history, and physical examination; diagnostic test results; consultant's reports (if any); proposed treatment by type (such as surgical, medical, and psychiatric); a description of who is or will be providing treatment (by discipline or specialty); anticipated frequency, medications, and specific goals of treatment; type of inpatient facility required and why (including length of time the related

inpatient stay will be required); and prognosis. If the treatment plan involves the transfer of a CHAMPUS patient from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the treatment plan documentation.

Uniformed Services. The Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA.

Veteran. A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

NOTE: Unless the veteran is eligible for "retired pay," "retirement pay," or "retainer pay," which refers to payments of a continuing nature and are payable at fixed intervals from the government for military service neither the veteran nor his or her dependents are eligible for benefits under CHAMPUS.

Well-Baby Care. A specific program of periodic health screening, developmental assessment, and routine immunization for children from birth up to 2 years.

Widow or Widower. A person who was a spouse at the time of death of the active duty member or retiree and who has not remarried.

Worker's Compensation Benefits. Medical benefits available under any worker's compensation law (including the Federal Employees Compensation Act), occupational disease law, employers liability law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure.

X-Ray Services. An x-ray examination from which an x-ray film or other image is produced, ordered by the attending physician when necessary and rendered in connection with a medical or surgical diagnosis or treatment of an illness or injury, or in connection with maternity or well-baby care.

CHAPTER 3

ELIGIBILITY

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CHAPTER 3 ELIGIBILITY

A. GENERAL

This chapter sets forth those persons who, by the provisions of 10 U.S.C., Chapter 55 (reference (a)), and the NATO Status of Forces Agreement (reference (n)), are eligible for CHAMPUS benefits. For additional statements concerning the special requirements of the PFTH, refer to Chapter 5 of this Regulation. A determination that a person is eligible does not entitle such a person automatically to CHAMPUS payments. Other chapters of this Regulation set forth additional requirements that must be met before any CHAMPUS benefits may be extended. Additionally, the use of CHAMPUS may be denied if a Uniformed Service medical facility capable of providing the needed care is available.

B. PERSONS ELIGIBLE

1. Retiree. A member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay based on duty in a Uniformed Service.

2. Dependent. A person who bears one of the following relationships to an active duty member (under a call or order that does not specify a period of 30 days or less), to a retiree, to a NATO member who is stationed in or passing through the United States on official business, or to a deceased person who at the time of death, was an active duty member or retiree.

NOTE: According to section 767 of the Department of Defense Appropriation Act, 1981 (reference (o)), from December 15, 1980, through September 30, 1981, spouses and children of NATO members are eligible only for outpatient CHAMPUS benefits while officially accompanying the NATO member who is stationed in or passing through the United States on official business. Availability of benefits after September 30, 1981, will depend on the language of future appropriation acts.

a. Spouse. A lawful husband or wife, regardless of whether or not dependent upon the active duty member or retiree.

b. Former Spouse. There are two groups of former spouses (i.e., spouses who were married to a military member or former member but whose marriage has been terminated by a final decree of divorce, dissolution, or annulment). To be eligible for CHAMPUS benefits, a former spouse must meet the criteria of subparagraphs B.2.b.(1) through B.2.b.(5) below and must qualify under the group defined in subparagraph B.2.b.(6)(a) or B.2.b.(6)(b).

- (1) Must be unremarried:
- (2) Must not be covered by an employer-sponsored health plan:
- (3) Must have been married to a member or former member who

performed at least 20 years of service which can be credited in determining the member's or former member's eligibility for retired or retainer pay;

(4) Must not be eligible for Part A of Title XVIII of the Social Security Act (Medicare);

(5) Must not be the dependent of a NATO member;

(6) Must meet the requirements of subparagraph B.2.b.(6)(a) or B.2.b.(6)(b) below:

(a) The former spouse must have been married to the same member or former member for at least 20 years, at least 20 of which were creditable in determining the member's or former member's eligibility for retired or retainer pay. Eligibility continues indefinitely unless affected by any of the conditions of subparagraphs B.2.b.(1) through B.2.b.(5).

1 If the date of the final decree of divorce, dissolution, or annulment was before February 1, 1983, the former spouse is eligible for CHAMPUS coverage of health care received on or after January 1, 1985.

2 If the date of the final decree of the divorce, dissolution, or annulment was on or after February 1, 1983, the former spouse is eligible for CHAMPUS coverage of health care which is received on or after the date of the divorce, dissolution, or annulment.

(b) The former spouse must have been married to the same military member or former member for at least 20 years, and at least 15, but less than 20 of those married years were creditable in determining the member's or former member's eligibility for retired or retainer pay.

1 If the date of the final decree of divorce, dissolution, or annulment is before April 1, 1985, the former spouse is eligible only for care received on or after January 1, 1985, or the date of the divorce, dissolution, or annulment, whichever is later. Eligibility continues indefinitely unless affected by any of the conditions of subparagraphs B.2.b.(1) through B.2.b.(5).

2 If the date of the final decree of divorce, dissolution or annulment is on or after April 1, 1985, but before September 29, 1988, the former spouse is eligible only for care received from the date of the decree of divorce, dissolution, or annulment until December 31, 1988, or for two years from the date of the divorce, dissolution, or annulment, whichever is later.

3 If the date of the final decree of divorce, dissolution, or annulment is on or after September 29, 1988, the former spouse is eligible only for care received within the 365 days (366 days in the case of a leap year) immediately following the date of the divorce, dissolution, or annulment.

4 Former spouses listed under paragraphs 2 and 3 above, who purchase a DoD designated health insurance policy upon termination of their

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eligibility, or within 90 days of termination of their eligibility, under paragraphs 2 and 3 above, are eligible for an additional year of coverage at military treatment facilities and under CHAMPUS for preexisting conditions. Preexisting conditions are those for which coverage is denied by the conversion health plan, solely because the conditions existed in the twelve months period prior to the purchase of the conversion insurance policy.

c. Widow or widower. A person who was a spouse at the time of death of the active duty member or retiree and who has not remarried.

d. Child. To be eligible, the child must be unremarried and a member of one of the classes set forth in subparagraph B.2.d.(1) or (2), below, and who also meets the requirements of subparagraph B.2.d.(3), below,

(1) Child of active duty member

(a) A legitimate child.

(b) An adopted child whose adoption has been legally completed. For eligibility under the provision, adoption must take place on or before the child's twenty-first birthday.

(c) A legitimate stepchild.

(d) An illegitimate child of a male member whose paternity has been determined judicially, or an illegitimate child of record of female member who has been directed judicially to support the child.

(e) An illegitimate child of a male active duty member whose paternity has not been determined judicially, or an illegitimate child of record of a female active duty member who (1) resides with or in a home provided by the member; and (2) is and continues to be dependent upon the member for over 50 percent of his or her support.

(f) An illegitimate child of the spouse of an active duty member (that is, the active duty member's stepchild) who (1) resides with or in a home provided by the active duty member or the parent who is the spouse of the member; and (2) is and continues to be dependent upon the member for over 50 percent of his or her support.

(2) Child of retiree, or of deceased member, or of deceased retiree

(a) A legitimate child.

(b) An adopted child whose adoption has been legally completed. For eligibility under this provision, adoption must take place on or before the child's twenty-first birthday.

(c) A legitimate stepchild.

(d) An illegitimate child of a male retiree whose paternity has been determined judicially, or an illegitimate child of record of a female retiree who has been directed judicially to support the child.

(e) An illegitimate child of a male retiree, or deceased male member or retiree whose paternity has not been determined judicially or an illegitimate child of record of a female retiree, or deceased female member or retiree who (1) resides with or in a home provided by the retiree, or which was being provided by the deceased member or retiree at the time of death; and (2) is and continues to be dependent upon the retiree for over 50 percent of his or her support, or who was so dependent on the deceased member or retiree at the time of death.

(f) An illegitimate child of the spouse of a retiree or deceased member or retiree (that is, the retiree's stepchild or stepchild of a deceased member or retiree at the time of death) who (1) resides with or in a home provided by the retiree or the parent who is the spouse of the retiree or was the spouse of the deceased member or retiree at the time of death; and (2) is and continues to be dependent upon the retiree for 50 percent of his or her support, or who was so dependent on the deceased member or retiree at the time of death.

(3) Additional requirements for a child who is a member of one of the classes in subparagraphs B.2.d.(1) and (2), above. The child must not be married. Additionally, he or she must be in one of the following three age groups:

(a) Not passed his or her 21st birthday.

(b) Passed his or her 21st birthday but incapable of self-support because of a mental or physical incapacity that existed before

his or her 21st birthday and dependent on the member or retiree for over 50 percent of his or her support, or dependent upon the member or retiree for over 50 percent of his or her support on the date of the member's or retiree's death. Such incapacity must be continuous. If the incapacity significantly improves or ceases at any time after age 21, even if such incapacity recurs subsequently, CHAMPUS eligibility cannot be reinstated on the basis of the incapacity. If the child was not handicapped mentally or physically at his or her 21st birthday, but becomes so incapacitated after that time, no CHAMPUS eligibility exists on the basis of the incapacity.

(c) Passed his or her 21st birthday but not his or her 23rd birthday, dependent upon the member or retiree for over 50 percent of his or her support, or dependent upon the member or retiree for over 50 percent of his or her support on the date of the member's or retiree's death, and pursuing a full-time course of education in an institution of higher learning approved by the Secretary of Defense or the Department of Education (as appropriate) or by a state agency under 38 U.S.C., Chapters 34 and 35 (reference (p)).

NOTE: Courses of education offered by institutions listed in the "Education Directory, Part 3, Higher Education" or "Accredited Higher Institutions" issued periodically by the Department of Education meet the criteria approved by the Secretary of Defense or the Department of Education (refer to subparagraph B.2.d.(3)(c) of this chapter). For determination of approval of courses offered by a foreign institution, by an institution not listed in either of the above directories, or by an institution not approved by a state agency pursuant to Chapters 34 and 35 of 38 U.S.C. (reference (p)), a statement may be obtained from the Department of Education, Washington, D.C. 20202.

C. BEGINNING DATES OF ELIGIBILITY

1. General. The beginning date of eligibility is dependent upon the class to which the person belongs and the date the person became a member of the class. Those who join after the class became eligible attain individual eligibility on the date they join.

2. Beginning dates of class eligibility

a. Spouse, legitimate child, adopted child, or (legitimate) stepchild of an active duty member

(1) For the medical benefits authorized by the Dependents' Medical Care Act of 1956 (reference (a)), December 7, 1956.

(2) For outpatient medical benefits under the Basic Program, October 1, 1966.

(3) For inpatient medical benefits under the Basic Program, January 1, 1967.

(4) For benefits under the PFTH, January 1, 1967.

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b. Retiree. For medical benefits under the Basic Program, January 1, 1967.

NOTE: Retirees and their dependents are not eligible for benefits of the PFTH.

c. Spouse, legitimate child, adopted child, or (legitimate) stepchild of a retiree or of a deceased member or retiree; widow or widower of deceased member or retiree. For medical benefits under the Basic Program, January 1, 1967.

NOTE: These classes do not have eligibility for benefits of the PFTH.

d. Illegitimate child of a male active duty member or retiree (or deceased member or retiree) whose paternity has been determined judicially or an illegitimate child of record of a female active duty member or retiree (or deceased member or retiree) who has been directed judicially to support the child. For all benefits for which otherwise eligible, August 31, 1972.

e. Illegitimate child of male active duty member or retiree (or deceased male member or retiree) whose paternity has not been determined judicially, or an illegitimate child of record of a female active duty member or retiree (or deceased female member or retiree) who resides with or in a home provided by the active duty member or retiree (or which was being provided by the deceased member or retiree at the time of death) and who is dependent on the member for over 50 percent of his or her support (or was so dependent on the deceased member or retiree at the time of death). For all benefits for which otherwise eligible, January 1, 1969.

f. Illegitimate child of the spouse of an active duty member or retiree (that is, the member or retiree's stepchild or stepchild of a deceased member or retiree at the time of death) who resides with or in a home provided by the active duty member or retiree, or the parent who is the spouse of the active duty member or retiree (or was the spouse of the deceased member or retiree at the time of death), and who is dependent upon the active duty member or retiree for over 50 percent of his or her support (or was so dependent on the deceased member or retiree at the time of death). For medical benefits under the Basic Program, January 1, 1969. For benefits under the PFTH, dependents of an active duty member only, January 1, 1969.

NOTE: Retirees or their dependents do not have eligibility for benefits of the PFTH.

D. DUAL COVERAGE

When an active duty member is also the dependent of another active duty member, a retiree, or a deceased active duty member or retiree, dual coverage, that is, entitlement to direct care from the Uniformed Services medical care system and CHAMPUS is the result. Since the active duty status is primary, and it is the intent that all medical care be provided an active duty member through the Uniformed Services medical care system, CHAMPUS eligibility of dual coverage is therefore terminated as of 12:01 a.m. on the day following

the day dual coverage begins. (However, any dependent children in a marriage of two active duty persons or an active duty member and a retiree, are CHAMPUS eligible in the same manner as dependent children of a marriage involving only one CHAMPUS sponsor.) Should a spouse or dependent who has dual coverage leave active duty status, that person's CHAMPUS eligibility is reinstated as of 12:01 a.m. of the day active duty ends, if he or she otherwise is eligible as a dependent of a CHAMPUS sponsor.

E. CHANGES IN AND TERMINATION OF ELIGIBILITY

1. Changes in status of active duty member. When an active duty member's period of active duty ends (for any reason other than retirement or death), his or her dependents lose their eligibility as of 12:01 a.m. of the day following the day the active duty ends. Entitlement to CHAMPUS benefits also ceases as of 12:01 a.m. of the day following the day a member is placed in desertion status. The member's dependent regains eligibility when the member is returned to military control. A member serving a sentence of confinement in conjunction with a sentence of a punitive discharge is still considered on active duty until such time as the discharge is executed.

2. Changes in status of retiree. Should a retiree cease to be entitled to retired, retainer, or equivalent pay for any reason, that person and his or her dependents lose their eligibility as of 12:01 a.m. of the day following the day the retiree ceases to be entitled to such pay unless such persons are otherwise eligible. A retiree who waives his or her retired, retainer, or equivalent pay is still considered a retiree for the purposes of CHAMPUS eligibility.

3. Changes in status of dependent.

a. Divorce. Except as provided in paragraph B.2.b. of this chapter, a spouse separated from an active duty member or retiree by a final divorce decree loses all eligibility based on his or her former marital relationship as of 12:01 a.m. of the day following the day the divorce becomes final. The eligibility of the member's or retiree's own children (including adopted and eligible illegitimate children) is unaffected by the divorce. An unadopted stepchild, however, loses eligibility with the termination of the marriage, also as of 12:01 a.m. the day following the day the divorce becomes final.

b. Annulment. Except as provided in paragraph B.2.b. of this chapter, a spouse whose marriage to an active duty member or retiree is dissolved by annulment loses eligibility as of 12:01 a.m. of the day following the date the court grants the annulment order. The fact that the annulment legally declares the entire marriage void from its inception does not affect the termination date of CHAMPUS eligibility. When there are children, the eligibility of the member's or retiree's own children (including adopted and eligible illegitimate children) is unaffected by the annulment. An unadopted stepchild, however, loses eligibility with the annulment of the marriage, also as of 12:01 a.m. of the day following the day the court grants the annulment order.

c. Adoption. A child of an active duty member or retiree who is adopted by a person, other than a person whose dependents are eligible for CHAMPUS benefits while the active duty member or retiree is living, thereby

severing the legal relationship between the child and the sponsor, loses eligibility as of 12:01 a.m. of the day following the day the adoption becomes final. However, an adoption occurring after the death of an active duty member or retiree would not result in loss of the child's eligibility, since there would be no termination of the legal relationship between the child and the deceased sponsor.

d. Marriage of child. A child of an active duty member or retiree, who marries a person whose dependents are not eligible for CHAMPUS, loses eligibility as of 12:01 a.m. on the day following the day of the marriage. However, should the marriage be terminated by death, divorce, or annulment before the child is 21 years old, the child again becomes a CHAMPUS eligible dependent as of 12:01 a.m. of the day following the day of the occurrence that terminates the marriage and continues up to age 21 if the child does not remarry before that time. If the marriage terminates after child's 21st birthday, there is no reinstatement of CHAMPUS eligibility.

e. Marriage of widow or widower. The remarriage of a widow or widower of an active duty member or retiree to a person whose dependents are not eligible for CHAMPUS terminates his or her CHAMPUS eligibility as of 12:01 a.m. of the day following the day of the marriage. Even if such remarriage should terminate for any reason, CHAMPUS benefits cannot be reinstated. However, the child of the widow or widower who was the stepchild of the deceased active duty member or retiree at the time of death continues to have the same CHAMPUS eligibility as other classes of dependent children.

f. Attainment of entitlement to hospital insurance benefits (Part A) under Medicare. Retirees, and all other CHAMPUS eligible persons except dependents of active duty members lose their eligibility for CHAMPUS if they become eligible for hospital insurance benefits (Part A) of Medicare. This is true even though the persons attaining such status live outside the United States where Medicare benefits are not available.

(1) Loss of CHAMPUS eligibility: Age. All CHAMPUS beneficiaries, except dependents of active duty members, and beneficiaries not eligible for Part A of Medicare, lose CHAMPUS eligibility at midnight on the last day of the month preceding the month of attainment of age 65. (For Medicare purposes, an individual attains age 65 the day before his or her 65th birthday.) If the person is not eligible for Part A of Medicare, he or she must file a Social Security Administration "Notice of Disallowance" certifying to that fact with the Uniformed Service responsible for the issuance of his or her identification card so a new card showing CHAMPUS eligibility can be issued.

(2) Loss of CHAMPUS eligibility: End stage renal disease and disability.

(a) End stage renal disease. Medicare coverage begins with the third month after the month a course of maintenance dialysis begins, or with the first month of dialysis if the individual participates in a self-dialysis training program during the 3-month waiting period, or with the month in which a patient enters the hospital to prepare to receive a transplant (providing the transplant is performed within the following 2 months). If a transplant is delayed more than 2 months after the preparatory hospitalization,

Medicare coverage will begin with the second month prior to the month of transplant. All beneficiaries, except dependents of active duty members, lose their CHAMPUS eligibility when Medicare coverage becomes available to a person because of chronic renal disease.

(b) Disability. Each case relating to Medicare eligibility resulting from being disabled requires individual investigation. All beneficiaries except dependents of active duty members lose their CHAMPUS eligibility when Medicare coverage becomes available to a disabled person.

(3) Reinstatement of CHAMPUS eligibility

(a) Age limitation. Beneficiaries who lose their CHAMPUS eligibility because they reached the age limitation and were eligible for Part A, cannot be reinstated under CHAMPUS.

(b) End stage renal disease. Medicare coverage ceases for end stage renal disease patients with the 36th month after the month in which a successful kidney transplant takes place or with the 12th month after the month in which the course of maintenance dialysis ends. At this point CHAMPUS eligibility resumes if the person is otherwise still eligible. He or she is required to take action to be reinstated as a CHAMPUS beneficiary and to obtain a new identification card.

(c) Disability. Some disabilities are permanent, others temporary. Each case must be reviewed individually. When disability ends and Medicare eligibility ceases, CHAMPUS eligibility resumes if the person is otherwise still eligible. Again, he or she is required to take action to obtain a new CHAMPUS identification card.

(4) Other Medicare entitlement. Entitlement only to supplementary medical insurance (Part B) of Medicare, but not Part A, or to Part A through the Premium-HI provision (provided for under the 1972 Amendments to the Social Security Act (reference (q))), does not affect CHAMPUS eligibility for any class of beneficiary. The only impact relates to double coverage (refer to Chapter 8 of this Regulation).

g. Disabling illness or injury of child age 21 or 22 who has eligibility based on his or her student status. A child 21 or 22 years old who is pursuing a full-time course of higher education and who, either during the school year or between semesters, suffers a disabling illness or injury with resultant inability to resume attendance at the institution remains eligible for CHAMPUS medical benefits for 6 months after the disability is removed or until the student passes his or her 23rd birthday, whichever occurs first. However, if recovery occurs before the 23rd birthday and there is resumption of a full-time course of higher education, CHAMPUS benefits can be continued until the 23rd birthday. The normal vacation periods during an established school year do not change the eligibility status of a dependent child 21 or 22 years old in full-time student status. Unless an incapacitating condition existed before, and at the time of, a dependent child's 21st birthday, a dependent child 21 or 22 years old in student status does not have eligibility related to mental or physical incapacity as described in subparagraph B.2.d.(3)(b) of this chapter.

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F. DETERMINATION OF ELIGIBILITY STATUS

1. Eligibility determinations responsibility of Uniformed Services. Determination of a person's eligibility as a CHAMPUS beneficiary is the responsibility of the Uniformed Service in which the active duty member, retiree, deceased member, or deceased retiree is, or was, a member, or in the case of dependents of a NATO military member, the Service that sponsors the NATO member. For the purpose of program integrity, the appropriate Uniformed Service shall, upon request of the Director, OCHAMPUS, review the eligibility of a specific person when there is reason to question the eligibility status. In such cases, a report on the result of the review and any action taken will be submitted to the Director, OCHAMPUS, or a designee.

2. Procedures for determination of eligibility. Procedures for the determination of eligibility and issuance of identification cards evidencing eligibility are prescribed by the following regulatory documents:

a. Department of Defense. DoD Instruction 1000.13 (reference (r)).

b. Army. AR 640-3 (reference (s)).

c. Navy.

(1) NAVPERS 15560, articles 4620150 (active duty members) and 4620250 (retired members) (reference (t)).

(2) NAVMILPERSCOMINST 1750.1 series, Uniformed Services Identification and Privilege Card (DD Form 1173); regulations governing (reference (t)).

d. Marine Corps

(1) MCO in P1900 series, Separation and Retirement Manual (DD Form 2MC-RETIRED) (reference (u)).

(2) MCO in P1750 series, Uniformed Services Identification and Privilege Card (DD Form 1173) (reference (u)).

e. Air Force. AFR 30-20 (reference (v)).

f. U.S. Public Health Service. CC29.2, Personnel Instruction 1 and 2 (reference (w)).

g. Coast Guard. Personnel Manual (CG 207, Chapter 13, Section E, and Chapter 18, Section C) (reference (x)).

h. NOAA. No published regulations. Identification cards are issued by Headquarters, NOAA, or the applications are verified by Headquarters, NOAA, and presented to any Uniformed Service facility for issuance of a card.

G. EVIDENCE OF ELIGIBILITY REQUIRED

Eligibility for CHAMPUS benefits will be verified through the DEERS (DoD 1341.1-M, reference (e)).

1. Acceptable evidence of eligibility

a. DEERS. Eligibility information established and maintained in the DEERS files is acceptable evidence of eligibility.

b. Identification cards or devices. When the DEERS file is not accessible immediately, acceptable preliminary evidence of eligibility includes valid identification cards or devices officially prescribed and issued by the appropriate Uniformed Service. Dependents identification cards must confirm CHAMPUS eligibility.

2. Responsibility for obtaining evidence of eligibility. It is the responsibility of the CHAMPUS beneficiary, or parent, or legal representative, when appropriate, to provide the necessary evidence required for entry into the DEERS file to establish CHAMPUS eligibility, and to ensure that all changes in status that may affect eligibility be reported immediately to the appropriate Uniformed Service for action. Ineligibility for CHAMPUS benefits may be presumed in the absence of prescribed eligibility evidence in the DEERS file or in the absence of a valid identification card or device.

CHAPTER 4

BASIC PROGRAM BENEFITS

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CHAPTER 4 BASIC PROGRAM BENEFITS

A. GENERAL

The CHAMPUS Basic Program is essentially a supplemental program to the Uniformed Services direct medical care system. The Basic Program is similar to private medical insurance programs, and is designed to provide financial assistance to CHAMPUS beneficiaries for certain prescribed medical care obtained from civilian sources.

1. Scope of benefits. Subject to all applicable definitions, conditions, limitations, or exclusions specified in this Regulation, the CHAMPUS Basic Program will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury, including maternity care and well-baby care. Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians, other authorized individual professional providers, and professional ambulance service, prescription drugs, authorized medical supplies, and rental or purchase of durable medical equipment.

2. Persons eligible for Basic Program benefits. Persons eligible to receive the Basic Program benefits are set forth in Chapter 3 of this Regulation. Any person determined to be an eligible CHAMPUS beneficiary is eligible for Basic Program benefits.

3. Authority to act for CHAMPUS. The authority to make benefit determinations and authorize the disbursement of funds under CHAMPUS is restricted to the Director, OCHAMPUS; designated OCHAMPUS staff; Director, OCHAMPUSEUR; or CHAMPUS fiscal intermediaries. No other persons or agents (such as physicians, staff members of hospitals, or CHAMPUS health benefits advisors) have such authority.

4. Status of patient controlling for purposes of cost-sharing. Benefits for covered services and supplies described in this chapter will be extended either on an inpatient or outpatient cost-sharing basis in accordance with the status of the patient at the time the covered services and supplies were provided, unless otherwise specifically designated (such as for ambulance service or maternity care). For cost-sharing provisions, refer to section F. of this chapter.

5. Right to information. As a condition precedent to the provision of benefits hereunder, OCHAMPUS or its CHAMPUS fiscal intermediaries shall be entitled to receive information from a physician or hospital or other person, institution, or organization (including a local, state, or U.S. Government agency) providing services or supplies to the beneficiary for which claims or requests for approval for benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, or examination or diagnosis of, or treatment rendered, or services and supplies furnished to a beneficiary, and shall be necessary for the accurate and efficient administration of CHAMPUS benefits. Before a determination will be made on a request for preauthorization or claim of benefits, a beneficiary or sponsor must provide particular additional information relevant to the requested determina-

tion, when necessary. The recipient of such information shall in every case hold such records confidential except when (a) disclosure of such information is authorized specifically by the beneficiary; (b) disclosure is necessary to permit authorized governmental officials to investigate and prosecute criminal actions, or (c) disclosure is authorized or required specifically under the terms of the Privacy Act or Freedom of Information Act (references (i) through (k)) (refer to section M. of chapter 1 of this Regulation). For the purposes of determining the applicability of and implementing the provisions of chapters 8, 11 and 12, or any provision of similar purpose of any other medical benefits coverage or entitlement, OCHAMPUS or CHAMPUS fiscal intermediaries may release, without consent or notice to any beneficiary or sponsor, to any person, organization, government agency, provider, or other entity any information with respect to any beneficiary when such release constitutes a routine use published in the Federal Register in accordance with DoD 5400.11-R (reference (k)). Before a person's claim of benefits will be adjudicated, the person must furnish to CHAMPUS information that reasonably may be expected to be in his or her possession and that is necessary to make the benefit determination. Failure to provide the requested information may result in denial of the claim.

6. Physical examinations. The Director, OCHAMPUS, or a designee, may require a beneficiary to submit to one or more medical (including psychiatric) examinations to determine the beneficiary's entitlement to benefits for which application has been made or for otherwise authorized medically necessary services and supplies required in the diagnosis or treatment of an illness or injury (including maternity and well-baby care). When a medical examination has been requested, CHAMPUS will withhold payment of any pending claims or preauthorization requests on that particular beneficiary. If the beneficiary refuses to agree to the requested medical examination, or unless prevented by a medical reason acceptable to OCHAMPUS, the examination is not performed within 90 days of initial request, all pending claims for services and supplies will be denied. A denial of payments for services or supplies provided before (and related to) the request for a physical examination is not subject to reconsideration. The medical examination and required beneficiary travel related to performing the requested medical examination will be at the expense of CHAMPUS. The medical examination may be performed by a physician in a Uniformed Services medical facility or by an appropriate civilian physician, as determined and selected by the Director, OCHAMPUS, or a designee who is responsible for making such arrangements as are necessary, including necessary travel arrangements.

7. Timely filing of claims. All claims submitted for benefits under this chapter must be filed with the appropriate CHAMPUS fiscal intermediary no later than December 31 of the calendar year immediately following the one in which the covered service or supply was rendered. Failure to file a claim timely waives automatically all rights to any benefits for such services or supplies (refer to Chapter 7 of this Regulation).

8. Double coverage and third party recoveries. CHAMPUS claims involving double coverage or the possibility that the United States can recover all or a part of its expenses from a third party, are specifically subject to the provisions of Chapter 8 or Chapter 12 of this Regulation as appropriate.

9. Nonavailability Statements (DD Forms 1251). In some geographic locations (or under certain special circumstances), it is necessary for a CHAMPUS beneficiary to determine whether the required medical care can be provided through a Uniformed Service facility. If the required medical care cannot be provided, the hospital commander, or a designee, will issue a Nonavailability Statement (DD Form 1251). Except for emergencies, a Nonavailability Statement should be issued before medical care is obtained from a civilian source. Failure to secure such a statement may waive the beneficiary's rights to benefits under CHAMPUS.

a. Rules applicable to issuance of Nonavailability Statement (DD Form 1251).

(1) The ASD(HA) is responsible for issuing rules and regulations regarding Nonavailability Statements.

(2) A Nonavailability Statement (NAS) is required for services in connection with nonemergency inpatient hospital care if such services are available at a facility of the Uniformed Services located within a 40-mile radius of the residence of the beneficiary, except that a NAS is not required for services otherwise available at a facility of the Uniformed Services located within a 40-mile radius of the beneficiary's residence when another insurance plan or program provides the beneficiary primary coverage for the services.

(3) An NAS is also required for selected outpatient procedures if such services are not available at a Uniformed Service facility (excluding facilities which are exclusively outpatient clinics) located within a 40-mile radius (catchment area) of the residence of the beneficiary. This does not apply to emergency services or for services for which another insurance plan or program provides the beneficiary primary coverage. Any changes to the selected outpatient procedures will be published in the Federal Register at least 30 days before the effective date of the change by the ASD(HA) and will be limited to the following categories: outpatient surgery and other selected outpatient procedures which have high unit costs and for which care may be available in military treatment facilities generally. The selected outpatient procedures will be uniform for all CHAMPUS beneficiaries.

b. Beneficiary responsibility. The beneficiary is responsible for securing information whether or not he or she resides in a geographic area that requires obtaining a Nonavailability Statement. Information concerning current rules and regulations may be obtained from the Offices of the Army, Navy, and Air Force Surgeon Generals; or a CHAMPUS health benefits advisor; or the Director, OCHAMPUS, or a designee; or from the appropriate CHAMPUS fiscal intermediary.

c. Rules in effect at time civilian medical care is provided apply. The applicable rules and regulations regarding Nonavailability Statements in effect at the time the civilian care is rendered apply in determining whether a Nonavailability Statement is required.

d. Nonavailability Statement (DD Form 1251) must be filed with applicable claim. When a claim is submitted for CHAMPUS benefits that includes services for which a Nonavailability Statement was issued, a valid Nonavailability Statement authorization must be on DEERS.

e. Nonavailability Statement (NAS) and claims adjudication.

(1) A NAS is valid for the adjudication of CHAMPUS claims for all related care otherwise authorized by this Regulation which is received from a civilian source while the beneficiary resided within the Uniformed Service facility catchment area which issued the NAS.

(2) A requirement for a NAS for inpatient hospital maternity care must be met for CHAMPUS cost-share of any related outpatient maternity care.

10. Utilization review and quality assurance. Before the extension of any CHAMPUS benefits under the Basic Program as outlined in this chapter, claims submitted for medical services and supplies rendered CHAMPUS beneficiaries are subject to review for quality of care and appropriate utilization. The Director, OCHAMPUS, or a designee, is responsible for utilization review and quality assurance and shall issue such generally accepted standards, norms, and criteria as are necessary to ensure compliance. Such utilization review and quality assurance standards, norms, and criteria shall include, but not be limited to, need for inpatient admission, length of inpatient stay, level of care, appropriateness of treatment, and level of institutional care required. Implementing instructions, procedures, and guidelines may provide for retrospective, concurrent, and prospective review, requiring both in-house and external review capability on the part of both CHAMPUS fiscal intermediaries and OCHAMPUS.

11. Preauthorization. Because CHAMPUS benefits are limited for certain types of care, the beneficiary is required to obtain preauthorization from the Director, OCHAMPUS, or a designee, before the services are provided. The types of care for which preauthorization is required are identified in other parts of this chapter.

a. Purpose of preauthorization. Preauthorization is required for those types of services for which coverage is limited or for which the conditions for coverage are highly technical. In such cases, the likelihood that CHAMPUS benefits will not be available is high. To minimize the risk that beneficiaries will incur costs that CHAMPUS cannot cover, the beneficiary is expected to request preauthorization of the care before the services are received. If a beneficiary fails to obtain preauthorization before receiving the services, the Director, OCHAMPUS, or a designee, may extend CHAMPUS benefits if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization.

b. Admissions to authorized institutions requiring preauthorization. When the Director, OCHAMPUS, requires preauthorization to an inpatient facility, the request for preauthorization is processed by OCHAMPUS or a designee. If the beneficiary elects to proceed with an admission prior to receiving written preauthorization from OCHAMPUS, authorization may be requested subsequently. If the stay in the institution is determined to be appropriate under the provisions of this Regulation, the Director, OCHAMPUS, or a designee, shall authorize benefits retroactively to the date of admission to the institution. If the stay is determined not to qualify under the provisions of this Regulation, the Director, or a designee, shall deny benefits as of the date the care failed to meet the requirements for coverage.

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c. Documentation for preauthorization - approved treatment plan. A request for preauthorization described in subsection A.11. of this chapter, requires submission of a detailed treatment plan, in accordance with guidelines and procedures issued by the Director, OCHAMPUS.

d. Other preauthorization requirements

(1) The Director, OCHAMPUS, or a designee, shall respond to all requests for preauthorization in writing and shall send notification of approval or denial to the beneficiary.

(2) The Director, OCHAMPUS, or a designee, shall specify, in the approved preauthorization, the services and supplies the approval covers.

(3) An approved preauthorization is valid only for 90 days from the date of issuance. If the preauthorized services and supplies are not obtained or commenced within the 90-day period, a new preauthorization request is required.

(4) A preauthorization may set forth other special limits or requirements as indicated by the particular case or situation for which preauthorization is being issued.

12. Implementing instructions. The Director, OCHAMPUS, or a designee, shall issue policies, instructions, procedures, guidelines, standards, or criteria as may be necessary to implement the intent of this Regulation.

B. INSTITUTIONAL BENEFITS

1. General. Services and supplies provided by an institutional provider authorized as set forth in Chapter 6 of this Regulation may be cost-shared only when such services or supplies (i) are otherwise authorized by this Regulation; (ii) are medically necessary; (iii) are ordered, directed, prescribed, or delivered by an OCHAMPUS-authorized individual professional provider as set forth in Chapter 6 of this Regulation or by an employee of the authorized institutional provider who is otherwise eligible to be a CHAMPUS authorized individual professional provider; (iv) are delivered in accordance with generally accepted norms for clinical practice in the United States; (v) meet established quality standards; and (vi) comply with applicable definitions, conditions, limitations, exceptions, or exclusions as otherwise set forth in this Regulation.

a. Billing practices. To be considered for benefits under this section B., covered services and supplies must be provided and billed for by a hospital or other authorized institutional provider. Such billings must be fully itemized and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. In the case of continuous care, claims shall be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor or, on a participating basis, directly by the facility on behalf of the beneficiary (refer to Chapter 7).

b. Successive inpatient admissions. Successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the active duty dependent's share of the inpatient institutional charges, provided not more than 60 days have elapsed between the successive admissions, except that successive inpatient admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions. For the purpose of applying benefits, successive admissions will be determined separately for maternity admissions and admissions related to an accidental injury (refer to section F. of this chapter).

c. Related services and supplies. Covered services and supplies must be rendered in connection with and related directly to a covered diagnosis or definitive set of symptoms requiring otherwise authorized medically necessary treatment.

d. Inpatient, appropriate level required. For purposes of inpatient care, the level of institutional care for which Basic Program benefits may be extended must be at the appropriate level required to provide the medically necessary treatment. If an appropriate lower level care facility is adequate, but is not available in the general locality, benefits may be continued in the higher level care facility, but CHAMPUS institutional benefit payments shall be limited to the allowable cost that would have been incurred in the appropriate lower level care facility, as determined by the Director, OCHAMPUS, or a designee. If it is determined that the institutional care can be provided reasonably in the home setting, no CHAMPUS institutional benefits are payable.

e. General or special education not covered. Services and supplies related to the provision of either regular or special education generally are not covered. Such exclusion applies whether a separate charge is made for education or whether it is included as a part of an overall combined daily charge of an institution. In the latter instance, that portion of the overall combined daily charge related to education must be determined, based on the allowable costs of the educational component, and deleted from the institution's charges before CHAMPUS benefits can be extended. The only exception is when appropriate education is not available from or not payable by the cognizant public entity. Each case must be referred to the Director, OCHAMPUS, or a designee, for review and a determination of the applicability of CHAMPUS benefits.

2. Covered hospital services and supplies

a. Room and board. Includes special diets, laundry services, and other general housekeeping support services (inpatient only).

b. General staff nursing services.

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c. ICU. Includes specialized units, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery (inpatient only).

d. Operating room, recovery room. Operating room and recovery room, including other special treatment rooms and equipment, and hyperbaric chamber.

e. Drugs and medicines. Includes sera, biologicals, and pharmaceutical preparations (including insulin) that are listed in the official formularies of the institution or facility at the time of use. (To be considered as an inpatient supply, drugs and medicines must be consumed during the specific period the beneficiary is a registered inpatient. Drugs and medicines prescribed for use outside the hospital, even though prescribed and obtained while still a registered inpatient, will be considered outpatient supplies and the provisions of section D. of this chapter will apply.)

f. Durable medical equipment, medical supplies, and dressings. Includes durable medical equipment, medical supplies essential to a surgical procedure (such as artificial heart valve and artificial ball and socket joint), sterile trays, casts, and orthopedic hardware. Use of durable medical equipment is restricted to an inpatient basis.

NOTE: If durable medical equipment is to be used on an outpatient basis or continued in outpatient status after use as an inpatient, benefits will be provided as set forth in section D. of this chapter and cost-sharing will be on an outpatient basis (refer to subsection A.4. of this chapter).

g. Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results. Also includes CT scanning under certain limited conditions.

h. Anesthesia. Includes both the anesthetic agent and its administration.

i. Blood. Includes blood, plasma and its derivatives, including equipment and supplies, and its administration.

j. Radiation therapy. Includes radioisotopes.

k. Physical therapy.

l. Oxygen. Includes equipment for its administration.

m. Intravenous injections. Includes solution.

n. Shock therapy.

o. Chemotherapy.

p. Renal and peritoneal dialysis.

q. Psychological evaluation tests. When required by the diagnosis.

r. Other medical services. Includes such other medical services as may be authorized by the Director, OCHAMPUS, or a designee, provided they are related directly to the diagnosis or definitive set of symptoms and rendered by a member of the institution's medical or professional staff (either salaried or contractual) and billed for by the hospital.

3. Covered services and supplies provided by special medical treatment institutions or facilities, other than hospitals or RTCs

a. Room and board. Includes special diets, laundry services, and other general housekeeping support services (inpatient only).

b. General staff nursing services.

c. Drugs and medicines. Includes sera, biologicals, and pharmaceutical preparations (including insulin) that are listed in the official formularies of the institution or facility at the time of use. (To be considered as an inpatient supply, drugs and medicines must be consumed during the specific period the beneficiary is a registered inpatient. Drugs and medicines prescribed for use outside the authorized institutional provider, even though prescribed and obtained while still a registered inpatient, will be considered outpatient supplies and the provisions of section D. of this chapter will apply.)

d. Durable medical equipment, medical supplies, and dressings. Includes durable medical equipment, sterile trays, casts, orthopedic hardware and dressings. Use of durable medical equipment is restricted to an inpatient basis.

NOTE: If the durable medical equipment is to be used on an outpatient basis or continued in outpatient status after use as an inpatient, benefits will be provided as set forth in section D. of this chapter, and cost-sharing will be on an outpatient basis (refer to subsection A.4. of this chapter).

e. Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results.

f. Blood. Includes blood, plasma and its derivatives, including equipment and supplies, and its administration.

g. Physical therapy.

h. Oxygen. Includes equipment for its administration.

i. Intravenous injections. Includes solution.

j. Shock therapy.

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k. Chemotherapy.

1. Psychological evaluation tests. When required by the diagnosis.

m. Renal and peritoneal dialysis.

n. Other medical services. Other medical services may be authorized by the Director, OCHAMPUS, or a designee, provided they are related directly to the diagnosis or definitive set of symptoms and rendered by a member of the institution's medical or professional staff (either salaried or contractual) and billed for by the authorized institutional provider of care.

4. Services and supplies provided by RTCs

a. Room and board. Includes use of residential facilities such as food service (including special diets), laundry services, supervised reasonable recreational and social activity services, and other general services as considered appropriate by the Director, OCHAMPUS, or a designee.

b. Patient assessment. Includes the assessment of each child or adolescent accepted by the RTC, including clinical consideration of each of his or her fundamental needs, that is, physical, psychological, chronological age, developmental level, family, educational, social, environmental, and recreational.

c. Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results.

d. Psychological evaluation tests.

e. Treatment of mental disorders. Services and supplies that are medically or psychologically necessary to diagnose and treat the mental disorder for which the patient was admitted to the RTC. Covered services and requirements for qualifications of providers are as listed in paragraph C.3.i. of this chapter.

f. Other necessary medical care. Emergency medical services or other authorized medical care may be rendered by the RTC provided it is professionally capable of rendering such services and meets standards required by the Director, OCHAMPUS. It is intended, however, that CHAMPUS payments to an RTC should primarily cover those services and supplies directly related to the treatment of mental disorders that require residential care.

5. Extent of institutional benefitsa. Inpatient room accommodations

(1) Semiprivate. The allowable costs for room and board furnished an individual patient are payable for semiprivate accommodations in a hospital or other authorized institution, subject to appropriate cost-sharing

provisions (refer to section F. of this chapter). A semiprivate accommodation is a room containing at least two beds. Therefore, if a room publicly is designated by the institution as a semiprivate accommodation and contains multiple beds, it qualifies as semiprivate for the purpose of CHAMPUS.

(2) Private. A room with one bed that is designated as a private room by the hospital or other authorized institutional provider. The allowable cost of a private room accommodation is covered only under the following conditions:

(a) When its use is required medically and when the attending physician certifies that a private room is necessary medically for the proper care and treatment of a patient; or

(b) When a patient's medical condition requires isolation;
or

(c) When a patient (in need of immediate inpatient care but not requiring a private room) is admitted to a hospital or other authorized institution that has semiprivate accommodations, but at the time of admission, such accommodations are occupied; or

(d) When a patient is admitted to an acute care hospital (general or special) without semiprivate rooms.

(3) Duration of private room stay. The allowable cost of private accommodations is covered under the circumstances described in subparagraph B.5.a.(2) of this chapter until the patient's condition no longer requires the private room for medical reasons or medical isolation; or, in the case of the patient not requiring a private room, when a semiprivate accommodation becomes available; or, in the case of an acute care hospital (general or special) which does not have semiprivate rooms, for the duration of an otherwise covered inpatient stay.

(4) Hospital (except an acute care hospital, general or special) or other authorized institutional provider without semiprivate accommodations. When a beneficiary is admitted to a hospital (except an acute care hospital, general or special) or other institution that has no semiprivate accommodations, for any inpatient day when the patient qualifies for use of a private room (as set forth in subparagraphs B.5.a.(2)(a) and (b), above), the allowable cost of private accommodations is covered. For any inpatient day in such a hospital or other authorized institution when the patient does not require medically the private room, the allowable cost of semiprivate accommodations is covered, such allowable costs to be determined by the Director, OCHAMPUS, or a designee.

b. General staff nursing services. General staff nursing services cover all nursing care (other than that provided by private duty nurses) including, but not limited to, general duty nursing, emergency room nursing, recovery room nursing, intensive nursing care, and group nursing arrangements. Only nursing services provided by nursing personnel on the payroll of the hospital or other authorized institution are eligible under this section B. If a nurse who is not on the payroll of the hospital or other

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authorized institution is called in specifically to care for a single patient (individual nursing) or more than one patient (group nursing), whether the patient is billed for the nursing services directly or through the hospital or other institution, such services constitute private duty (special) nursing services and are not eligible for benefits under this paragraph (the provisions of paragraph C.2.o. of this chapter would apply).

c. ICU. An ICU is a special segregated unit of a hospital in which patients are concentrated, by reason of serious illness, usually without regard to diagnosis. Special lifesaving techniques and equipment are available regularly and immediately within the unit, and patients are under continuous observation by a nursing staff specially trained and selected for the care of this type of patient. The unit is maintained on a continuing, rather than an intermittent or temporary, basis. It is not a postoperative recovery room or a postanesthesia room. In some large or highly specialized hospitals, the ICUs may be refined further for special purposes, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery. For purposes of CHAMPUS, these specialized units would be considered ICUs if they otherwise conformed to the definition of an ICU.

d. Treatment rooms. Standard treatment rooms include emergency rooms, operating rooms, recovery rooms, special treatment rooms, and hyperbaric chambers and all related necessary medical staff and equipment. To be recognized for purposes of CHAMPUS, treatment rooms must be so designated and maintained by the hospital or other authorized institution on a continuing basis. A treatment room set up on an intermittent or temporary basis would not be so recognized.

e. Drugs and medicines. Drugs and medicines are included as a supply of a hospital or other authorized institution only under the following conditions:

(1) They represent a cost to the facility rendering treatment;

(2) They are furnished to a patient receiving treatment, and are related directly to that treatment; and

(3) They are ordinarily furnished by the facility for the care and treatment of inpatients.

f. Durable medical equipment, medical supplies, and dressings. Durable medical equipment, medical supplies, and dressings are included as a supply of a hospital or other authorized institution only under the following conditions:

(1) If ordinarily furnished by the facility for the care and treatment of patients; and

(2) If specifically related to, and in connection with, the condition for which the patient is being treated; and

(3) If ordinarily furnished to a patient for use in the hospital or other authorized institution (except in the case of a temporary or disposable item); and

(4) Use of durable medical equipment is limited to those items provided while the patient is an inpatient. If such equipment is provided for use on an outpatient basis, the provisions of section D. of this chapter apply.

g. Transitional use items. Under certain circumstances, a temporary or disposable item may be provided for use beyond an inpatient stay, when such item is necessary medically to permit or facilitate the patient's departure from the hospital or other authorized institution, or which may be required until such time as the patient can obtain a continuing supply; or it would be unreasonable or impossible from a medical standpoint to discontinue the patient's use of the item at the time of termination of his or her stay as an inpatient.

h. Anesthetics and oxygen. Anesthetics and oxygen and their administration are considered a service or supply if furnished by the hospital or other authorized institution, or by others under arrangements made by the facility under which the billing for such services is made through the facility.

i. Inpatient mental health services. Inpatient mental health services are those services furnished by institutional and professional providers for treatment of a nervous or mental disorder (as defined in Chapter 2) to a patient admitted to a CHAMPUS-authorized acute care general hospital; a psychiatric hospital; or, unless otherwise exempted, a specialized treatment facility.

(1) Benefits limited to 60 days of inpatient care. CHAMPUS benefits for inpatient care are payable only so long as the inpatient level of care is medically or psychologically necessary and otherwise meets the requirements of this Regulation. In any case in which CHAMPUS benefits are paid for inpatient mental health services, such benefits will end automatically when payment has been made for 60 days of covered inpatient mental health services in a calendar year. This benefit limit applies whether the 60 days of paid inpatient mental health services are continuous or intermittent or involve one or more admissions to the same or different inpatient facilities. This limit on inpatient mental health services does not apply to services provided under the provisions of Chapter 5 of this Regulation; services provided on less than a 24-hour-a-day basis; or services provided in an authorized residential treatment center that meets the requirements of paragraph B.4.e. of Chapter 6 of this Regulation.

(2) Director, OCHAMPUS, may grant additional coverage. Upon written request by or on behalf of the beneficiary, the Director, OCHAMPUS, or a designee, taking into account the opinions of professional review, may grant coverage of inpatient mental health services in excess of 60 days in a calendar year when such services are found to be required because of extraordinary medical or psychological circumstances. Coverage in excess of 60 days may be granted if the Director, or a designee, determines that extraordinary medical

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or psychological circumstances exist based upon a written request documenting that:

(a) the patient is suffering from an acute mental disorder or an acute exacerbation of a chronic mental disorder that results in the patient being put at significant risk to self or of becoming a danger to others, and the patient requires a type, level, and intensity of otherwise authorized service that can only be provided in an acute care inpatient setting; or

(b) the patient has a serious medical condition apart from his or her psychiatric condition that requires a type, level, and intensity of service that can only be provided in an acute care inpatient setting and the person continues to need psychiatric care, but cannot obtain it on an out-patient basis because of his or her inpatient status. The medical condition and services provided must be otherwise covered under CHAMPUS.

6. Emergency inpatient hospital services. In the case of a medical emergency, benefits can be extended for medically necessary inpatient services and supplies provided to a beneficiary by a hospital, including hospitals that do not meet CHAMPUS standards or comply with the provisions of title VI of the Civil Rights Act (reference (z)), or satisfy other conditions herein set forth. In a medical emergency, medically necessary inpatient services and supplies are those that are necessary to prevent the death or serious impairment of the health of the patient, and that, because of the threat to the life or health of the patient, necessitate the use of the most accessible hospital available and equipped to furnish such services. The availability of benefits depends upon the following three separate findings and continues only as long as the emergency exists, as determined by medical review. If the case qualified as an emergency at the time of admission to an unauthorized institutional provider and the emergency subsequently is determined no longer to exist, benefits will be extended up through the date of notice to the beneficiary and provider that CHAMPUS benefits no longer are payable in that hospital.

a. Existence of medical emergency. A determination that a medical emergency existed with regard to the patient's condition;

b. Immediate admission required. A determination that the condition causing the medical emergency required immediate admission to a hospital to provide the emergency care; and

c. Closest hospital utilized. A determination that diagnosis or treatment was received at the most accessible (closest) hospital available and equipped to furnish the medically necessary care.

C. PROFESSIONAL SERVICES BENEFIT

1. General. Benefits may be extended for those covered services described in this section that are provided in accordance with good medical practice and established standards of quality by physicians or other authorized individual professional providers, as set forth in Chapter 6 of the Regulation. Such benefits are subject to all applicable definitions, conditions, exceptions, limitations, or exclusions as may be otherwise set forth

in this or other chapters of this Regulation. Except as otherwise specifically authorized, to be considered for benefits under this section C., the described services must be rendered by a physician, or prescribed, ordered, and referred medically by a physician to other authorized individual professional providers. Further, except under specifically defined circumstances, there should be an attending physician in any episode of care. (For example, certain services of a clinical psychologist are exempt from this requirement. For these exceptions, refer to Chapter 6.)

a. Billing practices. To be considered for benefits under this section C., covered professional services must be performed personally by the physician or other authorized individual professional provider, who is other than a salaried or contractual staff member of a hospital or other authorized institution, and who ordinarily and customarily bills on a fee-for-service basis for professional services rendered. Such billings must be itemized fully and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. For continuing professional care, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor, or directly by the physician or other authorized individual professional provider on behalf of a beneficiary (refer to Chapter 7 of this Regulation).

b. Services must be related. Covered professional services must be rendered in connection with and directly related to a covered diagnosis or definitive set of symptoms requiring medically necessary treatment.

2. Covered services of physicians and other authorized individual professional providers

a. Surgery. Surgery means operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and the following procedures:

- Bronchoscopy
- Laryngoscopy
- Thoracoscopy
- Catheterization of the heart
- Arteriograph thoracic lumbar
- Esophagoscopy
- Gastrosocopy
- Proctoscopy
- Sigmoidoscopy
- Peritoneoscopy
- Cystoscopy
- Colonoscopy
- Upper G.I. panendoscopy
- Encephalograph
- Myelography
- Discography
- Visualization of intracranial aneurysm by intracarotid injection of dye, with exposure of carotid artery, unilateral

Ventriculography

Insufflation of uterus and fallopian tubes for determination of tubal patency (Rubin's test of injection of radiopaque medium or for dilation)

Introduction of opaque media into the cranial arterial system, preliminary to cerebral arteriography, or into vertebral and subclavian systems

Intraspinal introduction of air preliminary to pneumoencephalography

Intraspinal introduction of opaque media preliminary to myelography

Intraventricular introduction of air preliminary to ventriculography

NOTE: The Director, OCHAMPUS, or a designee, shall determine such additional procedures that may fall within the intent of this definition of "surgery."

b. Surgical assistance.

c. Inpatient medical services.

d. Outpatient medical services.

e. Psychiatric services.

f. Consultation services.

g. Anesthesia services.

h. Radiation therapy services.

i. X-ray services.

j. Laboratory and pathological services.

k. Physical medicine services or physiatry services.

l. Maternity care.

m. Well-baby care.

n. Other medical care. Other medical care includes, but is not limited to, hemodialysis, inhalation therapy, shock therapy, and chemotherapy. The Director, OCHAMPUS, or a designee, shall determine those additional medical services for which benefits may be extended under this paragraph.

NOTE: A separate professional charge for the oral administration of approved antineoplastic drugs is not covered.

o. Private duty (special) nursing services.

p. Routine eye examinations. Coverage for routine eye examinations is limited to dependents of active duty members, to one examination per calendar year per person, and to services rendered on or after October 1, 1984.

3. Extent of professional benefits

a. Multiple surgery. In cases of multiple surgical procedures performed at the same time, benefits shall be determined as follows:

(1) If such multiple surgical procedures are for related conditions (whether or not, as in the case of cutting procedures, such care is performed through the same surgical opening or by the same surgical approach), benefits shall be limited to that part of the surgical care for which the greatest amount is payable under the applicable reimbursement method (refer to section E. of Chapter 6 of this Regulation). For the purposes of CHAMPUS, all procedures performed through the same surgical approach shall be considered to be related conditions.

(2) If the multiple surgical procedures are for unrelated conditions, benefits shall be extended as follows:

(a) 100 percent of the CHAMPUS-determined allowable charge for the major surgical procedure; and

(b) 50 percent of the CHAMPUS-determined allowable charge for each of the other surgical procedures; or

(c) Except that, if the multiple surgical procedures involve the fingers or toes, benefits for the first surgical procedure shall be at 100 percent of the CHAMPUS-determined allowable charge; the second at 50 percent; and the third and subsequent at 25 percent.

b. Different types of inpatient care, concurrent. If a beneficiary receives inpatient medical care during the same admission in which he or she also receives surgical care or maternity care, the beneficiary shall be entitled to the greater of the CHAMPUS-determined allowable charge for either the inpatient medical care or surgical or maternity care received, as the case may be, but not both; except that the provisions of this paragraph C.3.b. shall not apply if such inpatient medical care is for a diagnosed condition requiring inpatient medical care not related to the condition for which surgical care or maternity care is received, and is received from a physician other than the one rendering the surgical care or maternity care.

NOTE: This provision is not meant to imply that when extra time and special effort are required due to postsurgical or postdelivery complications, the attending physician may not request special consideration for a higher than usual charge.

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c. Need for surgical assistance. Surgical assistance is payable only when the complexity of the procedure warrants a surgical assistant (other than the surgical nurse or other such operating room personnel), subject to utilization review. In order for benefits to be extended for surgical assistance service, the primary surgeon may be required to certify in writing to the nonavailability of a qualified intern, resident, or other house physician. When a claim is received for a surgical assistant involving the following circumstances, special review is required to ascertain whether the surgical assistance service meets the medical necessity and other requirements of this section C.

- (1) If the surgical assistance occurred in a hospital that has a residency program in a specialty appropriate to the surgery;
- (2) If the surgery was performed by a team of surgeons;
- (3) If there were multiple surgical assistants; or
- (4) If the surgical assistant was a partner of or from the same group of practicing surgeons as the attending surgeon.

d. Aftercare following surgery. Except for those diagnostic procedures classified as surgery in this section C., and injection and needling procedures involving the joints, the benefit payments made for surgery (regardless of the setting in which it is rendered) include normal aftercare, whether the aftercare is billed for by the physician or other authorized individual professional provider on a global, all-inclusive basis, or billed for separately.

e. Cast and sutures, removal. The benefit payments made for the application of a cast or of sutures normally covers the postoperative care including the removal of the cast or sutures. When the application is made in one geographical location and the removal of the cast or sutures must be done in another geographical location, a separate benefit payment may be provided for the removal. The intent of this provision is to provide a separate benefit only when it is impracticable for the beneficiary to use the services of the provider that applied the cast originally. Benefits are not available for the services of a second provider if those services reasonably could have been rendered by the individual professional provider who applied the cast or sutures initially.

f. Inpatient care, concurrent. Concurrent inpatient care by more than one individual professional provider is covered if required because of the severity and complexity of the beneficiary's condition or because the beneficiary has multiple conditions that require treatment by providers of different specialties. Any claim for concurrent care must be reviewed before extending benefits in order to ascertain the condition of the beneficiary at the time the concurrent care was rendered. In the absence of such determination, benefits are payable only for inpatient care rendered by one attending physician or other authorized individual professional provider.

g. Consultants who become the attending surgeon. A consultation performed within 3 days of surgery by the attending physician is considered a preoperative examination. Preoperative examinations are an integral part of the surgery and a separate benefit is not payable for the consultation. If more than 3 days elapse between the consultation and surgery (performed by the same physician), benefits may be extended for the consultation, subject to review.

h. Anesthesia administered by the attending physician. A separate benefit is not payable for anesthesia administered by the attending physician (surgeon or obstetrician) or dentist, or by the surgical, obstetrical, or dental assistant.

i. Treatment of mental disorders. CHAMPUS benefits for the treatment of mental disorders are payable for beneficiaries who are outpatients or inpatients of CHAMPUS-authorized general or psychiatric hospitals, RTCs, or specialized treatment facilities, as authorized by the Director, OCHAMPUS, or a designee. All such services are subject to review for medical or psychological necessity and for quality of care. The Director, OCHAMPUS, reserves the right to require preauthorization of mental health services. Preauthorization may be conducted by the Director, OCHAMPUS, or a designee.

(1) Covered diagnostic and therapeutic services. Subject to the requirements and limitations stated, CHAMPUS benefits are payable for the following services when rendered in the diagnosis or treatment of a covered mental disorder by a CHAMPUS-authorized, qualified mental health provider practicing within the scope of his or her license. Qualified mental health providers are: psychiatrists or other physicians; clinical psychologists, certified psychiatric nurse specialists or clinical social workers; and marriage and family, pastoral, and mental health counselors, under a physician's supervision. No payment will be made for any service listed in this subparagraph C.3.i.(1) rendered by an individual who does not meet the criteria of Chapter 6 of this Regulation for his or her respective profession, regardless of whether the provider is an independent professional provider or an employee of an authorized professional or institutional provider.

(a) Individual psychotherapy, adult or child. A covered individual psychotherapy session is no more than 60 minutes in length. An individual psychotherapy session of up to 120 minutes in length is payable for crisis intervention.

(b) Group psychotherapy. A covered group psychotherapy session is no more than 90 minutes in length.

(c) Family or conjoint psychotherapy. A covered family or conjoint psychotherapy session is no more than 90 minutes in length. A family or conjoint psychotherapy session of up to 180 minutes in length is payable for crisis intervention.

(d) Psychoanalysis. Psychoanalysis is covered subject to specific review for medical or psychological necessity and appropriateness by the Director, OCHAMPUS, or a designee.

(e) Psychological testing and assessment.

(f) Administration of psychotropic drugs. When prescribed by an authorized provider qualified by licensure to prescribe drugs.

(g) Electroconvulsive treatment. When provided in accordance with guidelines issued by the Director, OCHAMPUS.

(h) Collateral visits. Covered collateral visits are those that are medically or psychologically necessary for the treatment of the patient and, as such, are considered as a psychotherapy session for purposes of subparagraph C.3.i.(2) of this chapter.

(2) Limitations and review requirements

(a) Outpatient psychotherapy. Outpatient psychotherapy generally is limited to a maximum of two psychotherapy sessions per week, in any combination of individual, family, conjoint, collateral, or group sessions. Before benefits can be extended for more than two outpatient psychotherapy sessions per week, professional review of the medical or psychological necessity for and appropriateness of the more intensive therapy is required.

(b) Inpatient psychotherapy. Coverage of inpatient psychotherapy is based on the medical or psychological necessity for the services identified in the patient's treatment plan. As a general rule, up to five psychotherapy sessions per week are considered appropriate. Additional sessions per week or more than one type of psychotherapy session performed on the same day (for example, an individual psychotherapy session and a family psychotherapy session on the same day) could be considered for coverage, depending on the medical or psychological necessity for the services. Benefits for inpatient psychotherapy will end automatically when the patient has received 60 days of covered inpatient mental health services in a calendar year, unless additional coverage is granted by the Director, OCHAMPUS. The Director, OCHAMPUS, shall issue specific guidelines for reviewing the medical and psychological necessity for and the quality of inpatient psychotherapy.

(3) Covered ancillary therapies. Includes art, music, dance, occupational, and other designated ancillary therapies, when included by the attending provider in an approved inpatient or outpatient treatment plan.

(4) Review of claims for treatment of mental disorder. The Director, OCHAMPUS, shall establish and maintain procedures for review, including professional review, of the services provided for the treatment of mental disorders.

j. Physical and occupational therapy

(1) Physical therapy. To be covered, physical therapy must be related to a covered medical condition. If performed by other than a physician, a physician (or other authorized individual professional provider acting within the scope of their license) shall

refer the patient for treatment and supervise the physical therapy. Generally, coverage of outpatient physical therapy is limited to a 60-day period, at up to two physical therapy sessions per week. Physical therapy beyond this length or frequency requires documentation of the medical necessity for the therapy and the anticipated results of the therapy. General exercise programs are not covered, even if recommended by a physician and conducted by qualified personnel. Passive exercises and range of motion exercises are not covered except when prescribed as an integral part of a comprehensive program of physical therapy.

(2) Occupational therapy. To be covered, occupational therapy must be related to a covered medical condition and must be directed to assisting the patient to overcome or compensate for disability resulting from illness, injury, or the effects of treatment of a covered condition. If performed by other than a physician, a physician shall prescribe the treatment and a physician shall supervise the occupational therapy. The occupational therapist providing the therapy shall be an employee of a CHAMPUS-authorized institutional provider and the services must be rendered in connection with CHAMPUS authorized care. Only those occupational therapy services that are rendered as part of an organized inpatient or outpatient rehabilitation program are covered. Occupational therapists are not considered CHAMPUS-authorized providers in their own right and may not submit bills on a fee-for-service basis. The employing institutional provider shall bill for the services of the occupational therapist.

k. Well-baby care. Benefits routinely are payable for well-baby care from birth up to the child's second birthday.

(1) The following services are payable when rendered as a part of a specific well-baby care program and when rendered by the attending pediatrician, family physician, or a pediatric nurse practitioner:

- (a) Newborn examination, PKU tests, and newborn circumcision.
- (b) History, physical examination, discussion, and counseling.
- (c) Vision, hearing, and dental screening.
- (d) Developmental appraisal.
- (e) Immunization (that is, DPT, polio, measles, mumps, and rubella).
- (f) Tuberculin test, hematocrit or Hgb., and urinalysis.

(2) Additional services or visits required because of specific findings or because of the particular circumstance of the individual case are covered if medically necessary and otherwise authorized for benefits under CHAMPUS.

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1. Private duty (special) nursing. Benefits are available for the skilled nursing services rendered by a private duty (special) nurse to a beneficiary requiring intensive skilled nursing care that can only be provided with the technical proficiency and scientific skills of an R.N. The specific skilled nursing services being rendered are controlling, not the condition of the patient or the professional status of the private duty (special) nurse rendering the services.

(1) Inpatient private duty (special) nursing services are limited to those rendered to an inpatient in a hospital that does not have an ICU. In addition, under specified circumstances, private duty (special) nursing in the home setting also is covered.

(2) The private duty (special) nursing care must be ordered and certified to be medically necessary by the attending physician.

(3) The skilled nursing care must be rendered by a private duty (special) nurse who is neither a member of the immediate family nor is a member of the beneficiary's household.

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(4) Private duty (special) nursing care does not, except incidentally, include providing services that provide or support primarily the essentials of daily living or acting as a companion or sitter.

(5) If the private duty (special) nursing care services being performed are primarily those that could be rendered by the average adult with minimal instruction or supervision, the services would not qualify as covered private duty (special) nursing services, regardless of whether performed by an R.N., regardless of whether or not ordered and certified to by the attending physician, and regardless of the condition of the patient.

(6) In order for such services to be considered for benefits, a private duty (special) nurse is required to maintain detailed daily nursing notes, whether the case involves inpatient nursing service or nursing services rendered in the home setting.

(7) Claims for continuing private duty (special) nursing care shall be submitted at least every 30 days. Each claim will be reviewed and the nursing care evaluated whether it continues to be appropriate and eligible for benefits.

(8) In most situations involving private duty (special) nursing care rendered in the home setting, benefits will be available only for a portion of the care, that is, providing benefits only for that time actually required to perform medically necessary skilled nursing services. If full-time private duty (special) nursing services are engaged, usually for convenience or to provide personal services to the patient, CHAMPUS benefits are payable only for that portion of the day during which skilled nursing services are rendered, but in no event is less than 1 hour of nursing care payable in any 24-hour period during which skilled nursing services are determined to have been rendered. Such situations often are better accommodated through the use of visiting nurses. This allows the personal services that are not coverable by CHAMPUS to be obtained at lesser cost from other than an R.N. Skilled nursing services provided by visiting nurses are covered under CHAMPUS.

NOTE: When the services of an R.N. are not available, benefits may be extended for the otherwise covered services of a L.P.N. or L.V.N.

D. OTHER BENEFITS

1. General. Benefits may be extended for the allowable charge of those other covered services and supplies described in this section D., which are provided in accordance with good medical practice and established standards of quality by those other authorized providers described in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, limitations, or exclusions as otherwise may be set forth in this or other chapters of this Regulation. To be considered for benefits under this section D., the described services or supplies must be prescribed and ordered by a physician. Other authorized individual professional providers acting within their scope of licensure may also prescribe and order these services and supplies unless otherwise specified in this section D. For example, durable medical equipment and cardiorespiratory monitors can only be ordered by a physician.

2. Billing practices. To be considered for benefits under this Section D., covered services and supplies must be provided and billed for by an authorized provider as set forth in Chapter 6 of this Regulation. Such billing must be itemized fully and described sufficiently, even when CHAMPUS payment is determined under the CHAMPUS DRG-based payment system, so that CHAMPUS can determine whether benefits are authorized by this Regulation. Except for claims subject to the CHAMPUS DRG-based payment system, whenever continuing charges are involved, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days (monthly) either by the beneficiary or sponsor or directly by the provider. For claims subject to the CHAMPUS DRG-based payment system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

3. Other covered services and supplies

a. Blood. If whole blood or plasma (or its derivatives) are provided and billed for by an authorized institution in connection with covered treatment, benefits are extended as set forth in section B. of this chapter. If blood is billed for directly to a beneficiary, benefits may be extended under this section D. in the same manner as a medical supply.

b. Durable medical equipment

(1) Scope of benefit. Subject to the exceptions in paragraphs (2) and (3) below, only durable medical equipment (DME) which is ordered by a physician for the specific use of the beneficiary, and which complies with the definition of "Durable Medical Equipment" in Chapter 2 of this Regulation, and which is not otherwise excluded by this Regulation qualifies as a Basic Program benefit.

(2) Cardiorespiratory monitor exception.

(a) When prescribed by a physician who is otherwise eligible as a CHAMPUS individual professional provider, or who is on active duty with a United States Uniformed Service, an electronic cardiorespiratory monitor, including technical support necessary for the proper use of the monitor, may be cost-shared as durable medical equipment when supervised by the prescribing physician for in-home use by:

1 An infant beneficiary who has had an apparent life-threatening event, as defined in guidelines issued by the Director, OCHAMPUS, or a designee, or,

2 An infant beneficiary who is a subsequent or multiple birth biological sibling of a victim of sudden infant death syndrome (SIDS), or,

3 An infant beneficiary whose birth weight was 1,500 grams or less, or,

4 An infant beneficiary who is a pre-term infant with pathologic apnea, as defined in guidelines issued by the Director, OCHAMPUS, or a designee, or,

5 Any beneficiary who has a condition or suspected condition designated in guidelines issued by the Director, OCHAMPUS, or designee, for which the in-home use of the cardiorespiratory monitor otherwise meets Basic Program requirements.

(b) The following types of services and items may be cost-shared when provided in conjunction with an otherwise authorized cardiorespiratory monitor:

1 Trend-event recorder, including technical support necessary for the proper use of the recorder.

2 Analysis of recorded physiological data associated with monitor alarms.

3 Professional visits for services otherwise authorized by this Regulation, and for family training on how to respond to an apparent life-threatening event.

4 Diagnostic testing otherwise authorized by this Regulation.

(3) Basic mobility equipment exception. A wheelchair, or a CHAMPUS-approved alternative, which is medically necessary to provide basic mobility, including reasonable additional cost for medically necessary modifications to accommodate a particular disability, may be cost-shared as durable medical equipment.

(4) Exclusions. DME which is otherwise qualified as a benefit is excluded as a benefit under the following circumstances:

(a) DME for a beneficiary who is a patient in a type of facility that ordinarily provides the same type of DME item to its patients at no additional charge in the usual course of providing its services.

(b) DME which is available to the beneficiary from a Uniformed Services Medical Treatment Facility.

(c) DME with deluxe, luxury, or immaterial features which increase the cost of the item to the government relative to similar item without those features.

(5) Basis for reimbursement. The cost of DME may be shared by the CHAMPUS based upon the price which is most advantageous to the government taking into consideration the anticipated duration of the medically necessary need for the equipment and current price information for the type of item. The cost analysis must include a comparison of the total price of the item as a monthly rental charge, a lease-purchase price, and a lump-sum purchase price and a provision for the time value of money at the rate determined by the U.S. Department of the Treasury.

c. Medical supplies and dressings (consumables). Medical supplies and dressings (consumables) are those that do not withstand prolonged, repeated use. Such items must be related directly to an appropriate and verified covered medical condition of the specific beneficiary for whom the item was purchased and obtained from a medical supply company, a pharmacy, or authorized institutional provider. Examples of covered medical supplies and dressings are disposable syringes for a known diabetic, colostomy sets, irrigation sets, and elastic bandages. An external surgical garment specifically designed for use following a mastectomy is considered a medical supply item.

NOTE: Generally, the allowable charge of a medical supply item will be under \$100. Any item over this amount must be reviewed to determine whether it would not qualify as a DME item. If it is, in fact, a medical supply item and does not represent an excessive charge, it can be considered for benefits under paragraph D.3.c., above.

d. Oxygen. Oxygen and equipment for its administration are covered. Benefits are limited to providing a tank unit at one location with oxygen limited to a 30-day supply at any one time. Repair and adjustment of CHAMPUS-purchased oxygen equipment also is covered.

e. Ambulance. Civilian ambulance service to, from, and between hospitals is covered when medically necessary in connection with otherwise covered services and supplies and a covered medical condition. Ambulance service also is covered for transfers to a Uniformed Service Medical Treatment Facility (USMTF). For the purpose of CHAMPUS payment, ambulance service is an outpatient service (including in connection with maternity care) with the exception of otherwise covered transfers between hospitals which are cost-shared on an inpatient basis. Ambulance transfers from a hospital based emergency room to another hospital more capable of providing the required care will also be cost-shared on an inpatient basis.

NOTE: The inpatient cost-sharing provisions for ambulance transfers only apply to otherwise covered transfers between hospitals; i.e., acute care, general, and special hospitals; psychiatric hospitals; and long-term hospitals.

(1) Ambulance service is covered for emergency transfers from a beneficiary's place of residence, accident scene, or other location to a USMTF, and for transfer to a USMTF after treatment at, or admission to, a civilian hospital, if ordered by other than a representative of the USMTF.

(2) Ambulance service cannot be used instead of taxi service and is not payable when the patient's condition would have permitted use of regular private transportation; nor is it payable when transport or transfer of a patient is primarily for the purpose of having the patient nearer to home, family, friends, or personal physician. Except as described in subparagraph D.3.e.(1), above, transport must be to closest appropriate facility by the least costly means.

(3) Vehicles such as medicabs or ambicabs function primarily as public passenger conveyances transporting patients to and from their medical appointments. No actual medical care is provided to the patients in transit. These types of vehicles do not qualify for benefits for the purpose of CHAMPUS payment.

(4) Ambulance services by other than land vehicles (such as a boat or airplane) may be considered only when the pickup point is inaccessible by a land vehicle, or when great distance or other obstacles are involved in transporting the patient to the nearest hospital with appropriate facilities and the patient's medical condition warrants speedy admission or is such that transfer by other means is contraindicated.

f. Prescription drugs and medicines. Prescription drugs and medicines that by U.S. law require a physician's or other authorized individual professional provider's prescription (acting within the scope of their license) and that are ordered or prescribed by a physician or other authorized individual professional provider (except that insulin is covered for a known diabetic, even though a prescription may not be required for its purchase) in connection with an otherwise covered condition or treatment, including Rh immune globulin.

(1) Drugs administered by a physician or other authorized individual professional provider as an integral part of a procedure covered under sections B. or C. of this chapter (such as chemotherapy) are not covered under this subparagraph inasmuch as the benefit for the institutional services or the professional services in connection with the procedure itself also includes the drug used.

(2) CHAMPUS benefits may not be extended for drugs not approved by the U.S. Food and Drug Administration for general use by humans (even though approved for testing with humans).

g. Prosthetic devices. The purchase of prosthetic devices is limited to artificial limbs and eyes, except those items that are inserted surgically into the body as an essential and integral part of an otherwise covered surgical procedure are not excluded.

NOTE: In order for CHAMPUS benefits to be extended, any surgical implant must be approved for use in humans by the U.S. Food and Drug Administration. Devices that are approved only for investigational use in humans are not payable.

h. Orthopedic braces and appliances. The purchase of leg braces (including attached shoes), arm braces, back braces, and neck braces is covered. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes or regular shoes subsequently built up, are not covered.

E. SPECIAL BENEFIT INFORMATION

1. General. There are certain circumstances, conditions, or limitations that impact the extension of benefits and that require special emphasis and explanation. This section E. sets forth those benefits and limitations recognized to be in this category. The benefits and limitations herein described also are subject to all applicable definitions, conditions, limitations, exceptions, and exclusions as set forth in this or other chapters of this Regulation, except as otherwise may be provided specifically in this section E.

2. Abortion. The statute under which CHAMPUS operates prohibits payment for abortions with one single exception--where the life of the woman would be endangered if the fetus were carried to term. Covered abortion services are limited to medical services and supplies only. Physician certification is required attesting that the abortion was performed because the mother's life would have been endangered if the fetus were carried to term. Abortions performed for suspected or confirmed fetal abnormality (e.g., anencephalic) or for mental health reasons (e.g., threatened suicide) do not fall within the exceptions permitted within the language of the statute and are not authorized for payment under CHAMPUS.

NOTE: Covered abortion services are limited to medical services or supplies only for the single circumstance outlined above and do not include abortion counseling or referral fees. Payment is not allowed for any services involving preparation for, or normal followup to, a noncovered abortion. The Director, OCHAMPUS, or a designee, shall issue guidelines describing the policy on abortion.

3. Family planning. The scope of the CHAMPUS family planning benefit is as follows:

a. Birth control (such as contraception)

(1) Benefits provided. Benefits are available for services and supplies related to preventing conception, including the following:

(a) Surgical insertion, removal, or replacement of intrauterine devices.

(b) Measurement for, and purchase of, contraceptive diaphragms (and later remeasurement and replacement).

(c) Prescription oral contraceptives.

(d) Surgical sterilization (either male or female).

(2) Exclusions. The family planning benefit does not include the following:

(a) Prophylactics (condoms).

(b) Spermicidal foams, jellies, and sprays not requiring a prescription.

(c) Services and supplies related to noncoital reproductive technologies, including but not limited to artificial insemination (including any costs related to donors or semen banks), in-vitro fertilization and gamete intrafallopian transfer.

(d) Reversal of a surgical sterilization procedure (male or female).

b. Genetic testing. Genetic testing essentially is preventive rather than related to active medical treatment of an illness or injury. However, under the family planning benefit, genetic testing is covered when performed in certain high risk situations. For the purpose of CHAMPUS, genetic testing includes tests to detect developmental abnormalities as well as purely genetic defects.

(1) Benefits provided. Benefits may be extended for genetic testing performed on a pregnant beneficiary under the following prescribed circumstances. The tests must be appropriate to the specific risk situation and must meet one of the following criteria:

(a) The mother-to-be is 35 years old or older; or

(b) The mother- or father-to-be has had a previous child born with a congenital abnormality; or

(c) Either the mother- or father-to-be has a family history of congenital abnormalities; or

(d) The mother-to-be contracted rubella during the first trimester of the pregnancy; or

(e) Such other specific situations as may be determined by the Director, OCHAMPUS, or a designee, to fall within the intent of this paragraph E.3.b.

(2) Exclusions. It is emphasized that routine or demand genetic testing is not covered. Further, genetic testing does not include the following:

(a) Tests performed to establish paternity of a child.

(b) Tests to determine the sex of an unborn child.

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4. Treatment of alcoholism. Emergency and inpatient hospital care for complications of alcoholism and detoxification are covered as for any other medical condition. Specific coverage for the treatment of alcoholism includes detoxification, rehabilitation, and outpatient care provided in authorized alcohol rehabilitation facilities.

a. Emergency and inpatient hospital services. Emergency and inpatient hospital services are covered when medically necessary for the active medical treatment of the acute phases of alcohol withdrawal (detoxification), for stabilization, and for treatment of medical complications of alcoholism. Emergency and inpatient hospital services are considered medically necessary only when the patient's condition is such that the personnel and facilities of a hospital are required. Stays provided for alcohol rehabilitation in a hospital-based rehabilitation facility are covered, subject to the provisions of paragraph E.4.b. of this chapter. Inpatient hospital services also are subject to the provisions regarding the limit on inpatient mental health services.

b. Authorized alcoholism treatment. Only those services provided in an organized alcoholism treatment program, by an authorized free-standing or hospital-based alcohol rehabilitation facility are covered. Covered services consist of any or all of the services listed below. A qualified mental health provider (physicians, clinical psychologists, clinical social workers, psychiatric nurse specialists) (see paragraph C.3.i.) shall prescribe the particular level of treatment. Each CHAMPUS beneficiary is entitled to three alcoholism treatment benefit periods in his or her lifetime. (A benefit period begins with the first date of covered alcoholism treatment and ends 365 days later, regardless of the total services actually used within the benefit period. Unused benefits cannot be carried over to subsequent benefit periods. Emergency and inpatient hospital services (as described in paragraph E.4.a. of this chapter) do not constitute alcoholism treatment for purposes of establishing the beginning of a benefit period.)

(1) Rehabilitative care. Rehabilitative care in an authorized alcohol rehabilitation facility, whether free-standing or hospital-based, is covered on either a residential or partial care (day or night program) basis. Coverage during a single benefit period is limited to no more than one inpatient stay (exclusive of stays classified in DRG 433) in hospitals subject to the CHAMPUS DRG-based payment system or 21 days in a DRG-exempt facility for rehabilitative care. If the patient is medically in need of alcohol detoxification, but does not require the personnel or facilities of a general hospital setting, detoxification services are covered in addition to the rehabilitative care, but in a DRG-exempt facility detoxification services are limited to 7 days. The medical necessity for the detoxification must be documented. Any detoxification services provided by the alcohol rehabilitation facility must be under general medical supervision.

(2) Outpatient care. Outpatient treatment provided by an approved alcohol rehabilitation facility, whether free-standing or hospital-based, is covered for up to 60 visits in a benefit period.

(3) Family therapy. Family therapy provided by an approved alcohol rehabilitation facility, whether free-standing or hospital-based, is covered for up to 15 visits in a benefit period.

c. Exclusions

(1) Aversion therapy. The programmed use of physical measures, such as electric shock, alcohol, or other drugs as negative reinforcement (aversion therapy) is not covered, even if recommended by a physician.

(2) Domiciliary settings. Domiciliary facilities, generally referred to as halfway or quarterway houses, are not authorized providers and charges for services provided by these facilities are not covered.

d. Confidentiality. Release of any patient identifying information, including that required to adjudicate a claim, must comply with the provisions of section 523 of the Health Service Act (HSA), as amended, (42 U.S.C. 290dd- 3), which governs the release of medical and other information from the records of patients undergoing treatment of alcoholism. If the patient refuses to authorize the release of medical records which are, in the opinion of the Director, OCHAMPUS, or a designee, necessary to determine benefits on a claim for treatment of alcoholism, the claim will be denied.

5. Organ transplants. Basic Program benefits are available for otherwise covered services or supplies in connection with an organ transplant procedure, provided such transplant procedure generally is in accordance with accepted professional medical standards and is not considered to be experimental or investigational.

a. Recipient costs. CHAMPUS benefits are payable for recipient costs when the recipient of the transplant is a beneficiary, whether or not the donor is a beneficiary.

b. Donor costs

(1) Donor costs are payable when both the donor and recipient are CHAMPUS beneficiaries.

(2) Donor costs are payable when the donor is a CHAMPUS beneficiary but the recipient is not.

(3) Donor costs are payable when the donor is the sponsor and the recipient is a beneficiary. (In such an event, donor costs are paid as a part of the beneficiary and recipient costs.)

(4) Donor costs also are payable when the donor is neither a CHAMPUS beneficiary nor a sponsor, if the recipient is a CHAMPUS beneficiary. (Again, in such an event, donor costs are paid as a part of the beneficiary and recipient costs.)

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c. General limitations

(1) If the donor is not a beneficiary, CHAMPUS benefits for donor costs are limited to those directly related to the transplant procedure itself and do not include any medical care costs related to other treatment of the donor, including complications.

(2) In most instances, for costs related to kidney transplants, Medicare (not CHAMPUS) benefits will be applicable. If a CHAMPUS beneficiary participates as a kidney donor for a Medicare beneficiary, Medicare will pay for expenses in connection with the kidney transplant to include all reasonable preparatory, operation and postoperation recovery expenses associated with the donation (postoperative recovery expenses are limited to the actual period of recovery). (Refer to paragraph E.3.f. of Chapter 3 of this Regulation.)

(3) Donor transportation costs are excluded whether or not the donor is a beneficiary.

(4) When the organ transplant is performed under a study, grant, or research program, no CHAMPUS benefits are payable for either recipient or donor cost.

d. Kidney acquisition. With specific reference to acquisition costs for kidneys, each hospital that performs kidney transplants is required for Medicare purposes to develop for each year separate standard acquisition costs for kidneys obtained from live donors and kidneys obtained from cadavers. The standard acquisition cost for cadaver kidneys is compiled by dividing the total cost of cadaver kidneys acquired by the number of transplants using cadaver kidneys. The standard acquisition cost for kidneys from live donors is compiled similarly using the total acquisition cost of kidneys from live donors and the number of transplants using kidneys from live donors. All recipients of cadaver kidneys are charged the same standard cadaver kidney acquisition cost and all recipients of kidneys from live donors are charged the same standard live donor acquisition cost. The appropriate hospital standard kidney acquisition costs (live donor or cadaver) required for Medicare in every instance must be used as the acquisition cost for purposes of providing CHAMPUS benefits.

e. Liver transplants. Effective July 1, 1983, CHAMPUS benefits are payable for services and supplies related to liver transplantation under the following circumstances only:

(1) Medical indications for liver transplantation. CHAMPUS shall provide benefits for services and supplies related to liver transplantation performed for beneficiaries suffering from irreversible liver injury who have exhausted alternative medical and surgical treatments, who are approaching the terminal phase of their illness, and who are considered appropriate for liver transplantation according to guidelines adopted by the Director, OCHAMPUS.

(2) Contraindications. CHAMPUS shall not provide coverage if any of the following contraindications exist:

(a) Active alcohol or other substance abuse;

(b) Malignancies metastasized to or extending beyond the margins of the liver; or

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(c) Viral-induced liver disease when viremia is still present.

(3) Specific covered services. CHAMPUS shall provide coverage for the following services related to liver transplantation:

(a) Medically necessary services to evaluate a potential candidate's suitability for liver transplantation, whether or not the patient is ultimately accepted as a candidate for transplantation;

(b) Medically necessary pre- and post-transplant inpatient hospital and outpatient services;

(c) Surgical services and related pre- and post-operative services of the transplant team;

(d) Services provided by a donor organ acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center;

(e) Medically necessary services required to maintain the viability of the donor organ following a formal declaration of brain death and after all existing legal requirements for excision of the donor organ have been met;

(f) Blood and blood products;

(g) Services and drugs required for immunosuppression, provided the drugs are approved by the United States Food and Drug Administration;

(h) Services and supplies, including inpatient care, which are medically necessary to treat complications of the transplant procedure, including management of infection and rejection episodes; and

(i) Services and supplies which are medically necessary for the periodic evaluation and assessment of the successfully transplanted patient.

(4) Specific noncovered services. CHAMPUS benefits will not be paid for the following:

(a) Services and supplies for which the beneficiary has no legal obligation to pay. For example, CHAMPUS shall not reimburse expenses that are waived by the transplant center, or for which research funds are available; and

(b) Out-of-hospital living expenses and any other non-medical expenses, including transportation, of the liver transplant candidate or family members, whether pre- or post-transplant.

(5) Implementation guidelines. The Director, OCHAMPUS, shall issue such guidelines as are necessary to implement the provision of this paragraph.

f. Heart Transplantation. CHAMPUS benefits are payable for services and supplies related to heart transplantation under the following circumstances:

(1) Medical indications for heart transplantation. CHAMPUS shall provide benefits for services and supplies related to heart transplantation performed for beneficiaries with end-stage cardiac disease who have exhausted alternative medical and surgical treatments, who have a very poor prognosis as a result of poor cardiac functional status, for whom plans for long-term adherence to a disciplined medical regimen are feasible, and who are considered appropriate for heart transplantation according to guidelines adopted by the Director, OCHAMPUS. However, benefits for heart transplantation are available only if the procedure is performed in a CHAMPUS-approved heart transplantation center or meets other certification or accreditation standards recognized by the Director, OCHAMPUS. See Chapter 6, paragraph B.4.c. of this Regulation.

(2) Specific covered services. CHAMPUS shall provide coverage for the following services related to heart transplantation:

(a) Medically necessary services to evaluate a potential candidate's suitability for heart transplantation, whether or not the patient is ultimately accepted as a candidate for transplantation;

(b) Medically necessary pre- and post-transplant inpatient hospital and outpatient services;

(c) Surgical services and related pre- and post-operative services of the transplant team;

(d) Services provided by the donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center;

(e) Medically necessary services required to maintain the viability of the donor organ following a formal declaration of brain death and after all existing legal requirements for excision of the donor organ have been met;

(f) Blood and blood products;

(g) Services and drugs required for immunosuppression, provided the drugs are approved by the United States Food and Drug Administration;

(h) Services and supplies, including inpatient care, which are medically necessary to treat complications of the transplant procedure, including management of infection and rejection episodes; and

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(i) Services and supplies which are medically necessary for the periodic evaluation and assessment of the successfully transplanted patient.

(3) Noncovered services. CHAMPUS benefits will not be paid for the following:

(a) Services and supplies for which the beneficiary has no legal obligation to pay; and

(b) Out-of-hospital living expenses and any other non-medical expenses, including transportation of the heart transplant candidate or family members, whether pre- or post-transplant.

(4) Implementation guidelines. The Director, OCHAMPUS, shall issue such guidelines as are necessary to implement the provisions of this paragraph.

6. Eyeglasses, spectacles, contact lenses, or other optical devices. Eyeglasses, spectacles, contact lenses, or other optical devices are excluded under the Basic Program except under very limited and specific circumstances.

a. Exception to general exclusion. Benefits for glasses and lenses may be extended only in connection with the following specified eye conditions and circumstances:

(1) Eyeglasses or lenses that perform the function of the human lens, lost as the result of intraocular surgery or ocular injury or congenital absence.

NOTE: Notwithstanding the general requirement for U.S. Food and Drug Administration approval of any surgical implant set forth in paragraph D.3.g. of this chapter, intraocular lenses are authorized under CHAMPUS if they are either approved for marketing by the FDA or are subject to an investigational device exemption.

(2) "Pinhole" glasses prescribed for use after surgery for detached retina.

(3) Lenses prescribed as "treatment" instead of surgery for the following conditions:

(a) Contact lenses used for treatment of infantile glaucoma.

(b) Corneal or scleral lenses prescribed in connection with treatment of keratoconus.

(c) Scleral lenses prescribed to retain moisture when normal tearing is not present or is inadequate.

(d) Corneal or scleral lenses prescribed to reduce a corneal irregularity other than astigmatism.

b. Limitations. The specified benefits are limited further to one set of lenses related to one of the qualifying eye conditions set forth in paragraph E.6.a., above. If there is a prescription change requiring a new set of lenses (but still related to the qualifying eye condition), benefits may be extended for a second set of lenses, subject to specific medical review.

7. Transsexualism or such other conditions as gender dysphoria. All services and supplies directly or indirectly related to transsexualism or such other conditions as gender dysphoria are excluded under CHAMPUS. This exclusion includes, but is not limited to, psychotherapy, prescription drugs, and intersex surgery that may be provided in connection with transsexualism or such other conditions as gender dysphoria. There is only one very limited exception to this general exclusion, that is, notwithstanding the definition of congenital anomaly, CHAMPUS benefits may be extended for surgery and related medically necessary services performed to correct sex gender confusion (that is, ambiguous genitalia) which has been documented to be present at birth.

8. Cosmetic, reconstructive, or plastic surgery. For the purposes of CHAMPUS, cosmetic, reconstructive, or plastic surgery is surgery that can be expected primarily to improve physical appearance or that is performed primarily for psychological purposes or that restores form, but does not correct or improve materially a bodily function.

NOTE: If a surgical procedure primarily restores function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subsection E.8.

a. Limited benefits under CHAMPUS. Benefits under the Basic Program generally are not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances, benefits for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

- (1) Correction of congenital anomaly; or
- (2) Restoration of body form following an accidental injury; or
- (3) Revision of disfiguring and extensive scars resulting from neoplastic surgery
- (4) Reconstructive breast surgery following a medically necessary mastectomy performed for the treatment of carcinoma, severe fibrocystic disease, other nonmalignant tumors or traumatic injuries.
- (5) Penile implants and testicular prostheses for conditions resulting from organic origins (i.e., trauma, radical surgery, disease process, for correction of congenital anomaly, etc.). Also penile implants for organic impotency.

NOTE: Organic impotence is defined as that which can be reasonably expected to occur following certain diseases, surgical procedures, trauma, injury, or congenital malformation. Impotence does not become organic because of psychological or psychiatric reasons.

(6) Generally, benefits are limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than December 31 of the year following the year in which the related accidental injury or surgical trauma occurred, except for authorized postmastectomy breast reconstruction for which there is no time limitation between mastectomy and reconstruction. Also, special consideration for exception will be given to cases involving children who may require a growth period.

b. General exclusions

(1) For the purposes of CHAMPUS, dental congenital anomalies such as absent tooth buds or malocclusion specifically are excluded. Also excluded are any procedures related to transsexualism or such other conditions as gender dysphoria except as provided in subsection E.7., above.

(2) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process also are excluded.

(3) Procedures performed for elective correction of minor dermatological blemishes and marks or minor anatomical anomalies also are excluded.

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(4) In addition, whether or not it would otherwise qualify for benefits under paragraph E.8.a., above, the breast augmentation mammoplasty is specifically excluded.

c. Noncovered surgery, all related services and supplies excluded.

When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for CHAMPUS benefits, all related services and supplies are excluded, including any institutional costs.

d. Examples of noncovered cosmetic, reconstructive, or plastic surgery procedures. The following is a partial list of cosmetic, reconstructive, or plastic surgery procedures that do not qualify for benefits under CHAMPUS. This list is for example purposes only and is not to be construed as being all-inclusive.

(1) Any procedure performed for personal reasons to improve the appearance of an obvious feature or part of the body that would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures that are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties, except for those performed as a part of postmastectomy breast reconstruction as specifically authorized in subparagraph E.8.a.(4) of this chapter.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction mammoplasties (unless there is medical documentation of intractable pain, not amenable to other forms of treatment, resulting from large, pendulous breasts).

(6) Panniculectomy; body sculpture procedures.

(7) Repair of sagging eyelids (without demonstrated and medically documented significant impairment of vision).

(8) Rhinoplasties (without evidence of accidental injury occurring within the previous 6 months that resulted in significant obstruction of breathing).

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Elective correction of minor dermatological blemishes and marks or minor anatomical anomalies.

(12) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(13) Removal of tattoos.

(14) Hair transplants.

(15) Electrolysis.

(16) Any procedures related to transsexualism or such other conditions as gender dysphoria except as provided in subsection E.7. of this chapter.

(17) Penile implant procedure for psychological impotency, transsexualism or such other conditions as gender dysphoria.

(18) Insertion of prosthetic testicles for transsexualism or such other conditions as gender dysphoria.

9. Complications (unfortunate sequelae) resulting from noncovered initial surgery or treatment. Benefits are available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident of treatment (such as nonadjunctive dental care, transsexual surgery, and cosmetic surgery) but only if the later complication represents a separate medical condition such as a systemic infection, cardiac arrest, and acute drug reaction. Benefits may not be extended for any later care or procedures related to the complication that essentially is similar to the initial noncovered care. Examples of complications similar to the initial episode of care (and thus not covered) would be repair of facial scarring resulting from dermabrasion for acne or repair of a prolapsed vagina in a biological male who had undergone transsexual surgery.

10. Dental. CHAMPUS does not include a dental benefit. Under very limited circumstances, benefits are available for dental services and supplies when the dental services are adjunctive to otherwise covered medical treatment.

a. Adjunctive dental care, limited. Adjunctive dental care is limited to those services and supplies provided under the following conditions:

(1) Dental care which is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition and is essential to the control of the primary medical condition. The following is a list of conditions for which CHAMPUS benefits are payable under this provision:

- (a) Intraoral abscesses which extend beyond the dental alveolus.
- (b) Extraoral abscesses.
- (c) Cellulitis and osteitis which is clearly exacerbating and directly affecting a medical condition currently under treatment.
- (d) Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.
- (e) Myofacial Pain Dysfunction Syndrome.
- (f) Total or complete ankyloglossia.
- (g) Adjunctive dental and orthodontic support for cleft palate.
- (h) The prosthetic replacement of either the maxilla or the mandible due to the reduction of body tissues associated with traumatic injury (e.g., impact, gun shot wound), in addition to services related to treating neoplasms or iatrogenic dental trauma.

NOTE: The test of whether dental trauma is covered is whether the trauma is solely dental trauma. Dental trauma, in order to be covered, must be related to, and an integral part of medical trauma; or a result of medically necessary treatment of an injury or disease.

(2) Dental care required in preparation for medical treatment of a disease or disorder or required as the result of dental trauma caused by the medically necessary treatment of an injury or disease (iatrogenic).

(a) Necessary dental care including prophylaxis and extractions when performed in preparation for or as a result of in-line radiation therapy for oral or facial cancer.

(b) Treatment of gingival hyperplasia, with or without periodontal disease, as a direct result of prolonged therapy with Dilantin (diphenylhydantoin) or related compounds.

(c) Dental care is limited to the above and similar conditions specifically prescribed by the Director, OCHAMPUS, as meeting the requirements for coverage under the provisions of this section.

b. General exclusions.

(1) Dental care which is routine, preventative, restorative, prosthodontic, periodontic or emergency does not qualify as adjunctive dental care for the purposes of CHAMPUS except when performed in preparation for or as a result of dental trauma caused by medically necessary treatment of an injury or disease.

(2) The adding or modifying of bridgework and dentures.

(3) Orthodontia, except when directly related to and an integral part of the medical or surgical correction of a cleft palate or when required in preparation for, or as a result of, trauma to the teeth and supporting structures caused by medically necessary treatment of an injury or disease.

c. Preauthorization required. In order to be covered, adjunctive dental care requires preauthorization from the Director, OCHAMPUS, or a designee, in accordance with subsection A.11. of this chapter. When adjunctive dental care involves a medical (not dental) emergency (such as facial injuries resulting from an accident), the requirement for preauthorization is waived. Such waiver, however, is limited to the essential adjunctive dental care related to the medical condition requiring the immediate emergency treatment. A complete explanation, with supporting medical documentation, must be submitted with claims for emergency adjunctive dental care.

d. Covered oral surgery. Notwithstanding the above limitations on dental care, there are certain oral surgical procedures that are performed by both physicians and dentists, and that are essentially medical rather than dental care. For the purposes of CHAMPUS, the following procedures, whether performed by a

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physician or dentist, are considered to be in this category and benefits may be extended for otherwise covered services and supplies without preauthorization:

- (1) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, and roof and floor of the mouth, when such conditions require a pathological (histological) examination.
- (2) Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, and roof and floor of the mouth.
- (3) Treatment of oral or facial cancer.
- (4) Treatment of fractures of facial bones.
- (5) External (extra-oral) incision and drainage of cellulitis.
- (6) Surgery of accessory sinuses, salivary glands, or ducts.
- (7) Reduction of dislocations and the excision of the temporomandibular joints, when surgery is a necessary part of the reduction.
- (8) Any oral surgical procedure that falls within the cosmetic, reconstructive, or plastic surgery definition is subject to the limitations and requirements set forth in subsection E.8. of this chapter.

NOTE: Extraction of unerupted or partially erupted, malposed or impacted teeth, with or without the attached follicular or development tissues, is not a covered oral surgery procedure except when the care is indicated in preparation for medical treatment of a disease or disorder or required as a result of dental trauma caused by the necessary medical treatment of an injury or illness. Surgical preparation of the mouth for dentures is not covered by CHAMPUS.

e. Inpatient hospital stay in connection with nonadjunctive, noncovered dental care. Institutional benefits specified in section B. of this chapter may be extended for inpatient hospital stays related to noncovered, nonadjunctive dental care when such inpatient stay is medically necessary to safeguard the life of the patient from the effects of dentistry because of the existence of a specific and serious nondental organic impairment currently under active treatment. (Hemophilia is an example of a condition that could be considered a serious nondental impairment.) Preauthorization by the Director, OCHAMPUS, or a designee, is required for such inpatient stays to be covered in the same manner as required for adjunctive dental care described in paragraph E.10.c. of this chapter. Regardless of whether or not the preauthorization request for the hospital admission is approved and thus qualifies for institutional benefits, the professional service related to the nonadjunctive dental care is not covered.

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11. Drug abuse. Under the Basic Program, benefits may be extended for medically necessary prescription drugs required in the treatment of an illness or injury or in connection with maternity care (refer to section D. of this chapter). However, CHAMPUS benefits cannot be authorized to support or maintain an existing or potential drug abuse situation, whether or not the drugs (under other circumstances) are eligible for benefit consideration and whether or not obtained by legal means.

a. Limitations on who can prescribe drugs. CHAMPUS benefits are not available for any drugs prescribed by a member of the beneficiary's family or by a nonfamily member residing in the same household with the beneficiary or sponsor.

b. Drug maintenance programs excluded. Drug maintenance programs when one addictive drug is substituted for another on a maintenance basis (such as methadone substituted for heroin) are not covered. This exclusion applies even in areas outside the United States where addictive drugs are dispensed legally by physicians on a maintenance dosage level.

c. Kinds of prescription drugs that are monitored carefully by CHAMPUS for possible abuse situations.

(1) Narcotics. Examples are Morphine and Demerol.

- (2) Nonnarcotic analgesics. Examples are Talwin and Darvon.
- (3) Tranquilizers. Examples are Valium, Librium, and Meproamate.
- (4) Barbiturates. Examples are Seconal and Nembutal.
- (5) Nonbarbiturate hypnotics. Examples are Doriden and Chloral Hydrate.
- (6) Stimulants. Examples are amphetamines.

d. CHAMPUS fiscal intermediary responsibilities. CHAMPUS fiscal intermediaries are responsible for implementing utilization control and quality assurance procedures designed to identify possible drug abuse situations. The CHAMPUS fiscal intermediary is directed to screen all drug claims for potential overutilization and irrational prescribing of drugs, and to subject any such cases to extensive review to establish the necessity for the drugs and their appropriateness on the basis of diagnosis or definitive symptoms.

- (1) When a possible drug abuse situation is identified, all claims for drugs for that specific beneficiary or provider will be suspended pending the results of a review.
- (2) If the review determines that a drug abuse situation does in fact exist, all drug claims held in suspense will be denied.
- (3) If the record indicates previously paid drug benefits, the prior claims for that beneficiary or provider will be reopened and the circumstances involved reviewed to determine whether or not drug abuse also existed at the time the earlier claims were adjudicated. If drug abuse is later ascertained, benefit payments made previously will be considered to have been extended in error and the amounts so paid recouped.
- (4) Inpatient stays primarily for the purpose of obtaining drugs and any other services and supplies related to drug abuse also are excluded.

e. Unethical or illegal provider practices related to drugs. Any such investigation into a possible drug abuse that uncovers unethical or illegal drug dispensing practices on the part of an institution, a pharmacy, or physician will be referred to the professional or investigative agency having jurisdiction. CHAMPUS fiscal intermediaries are directed to withhold payment of all CHAMPUS claims for services and supplies rendered by a provider under active investigation for possible unethical or illegal drug dispensing activities.

f. Detoxification. The above monitoring and control of drug abuse situations shall in no way be construed to deny otherwise covered medical services and supplies related to drug detoxification (including newborn, addicted infants) when medical supervision is required.

12. Custodial care. The statute under which CHAMPUS operates specifically excludes custodial care. Many beneficiaries and sponsors misunderstand what is meant by custodial care, assuming that because custodial care is not covered, it implies the custodial care is not necessary. This is not the case; it only means the care being provided is not a type of care for which CHAMPUS benefits can be extended.

a. Kinds of conditions that can result in custodial care. There is no absolute rule that can be applied. With most conditions, there is a period of active treatment before custodial care, some much more prolonged than others. Examples of potential custodial care cases may be a spinal cord injury resulting in extensive paralysis, a severe cerebral vascular accident, multiple sclerosis in its latter stages, or presenile and senile dementia. These conditions do not result necessarily in custodial care but are indicative of the types of conditions that sometimes do. It is not the condition itself that is controlling, but whether the care being rendered falls within the definition of custodial care (refer to Chapter 2 of this Regulation for the definition of "custodial care").

b. Benefits available in connection with a custodial care case. CHAMPUS benefits are not available for services related to a custodial care case, with the following specific exceptions:

(1) Prescription drugs and medicines, medical supplies and durable medical equipment. Benefits are payable for otherwise covered prescription drugs and medicines, medical supplies and durable medical equipment.

(2) Nursing services, limited. Recognizing that even though the care being received is determined primarily to be custodial, an occasional specific skilled nursing service may be required. When it is determined such skilled nursing services are needed, benefits may be extended for 1 hour of nursing care per day.

(3) Physician services, limited. Recognizing that even though the care being received is determined primarily to be custodial, occasional physician monitoring may be required to maintain the patient's condition. When it is determined that a patient is receiving custodial care, benefits may be extended for up to twelve physician visits per calendar year for the custodial condition (not to exceed one per month).

NOTE: CHAMPUS benefits may be extended for additional physician visits related to the treatment of a condition other than the condition for which the patient is receiving custodial care (an example is a broken leg as a result of a fall).

(4) Payment for prescription drugs, medical supplies, durable medical equipment and limited skilled nursing and physician services does not affect custodial care determination. The fact that CHAMPUS extends benefits for prescription drugs, medical supplies, durable medical equipment, and limited skilled nursing and physician services in no way affects the custodial care determination if the case otherwise falls within the definition of custodial care.

c. Exception to custodial care exclusion, admission to a hospital. CHAMPUS benefits may be extended for otherwise covered services or supplies directly related to a medically necessary admission to an acute care general or special hospital (as defined in paragraph B.4 a., Chapter 6, of this Regulation), if the care is at the appropriate level and meets other requirements of this Regulation.

d. Reasonable care for which benefits were authorized or reimbursed before June 1, 1977. It is recognized that care for which benefits were authorized or reimbursed before the implementation date of the Regulation may be excluded under the custodial care limitations set forth in this Regulation. Therefore, an exception to the custodial care limitations set forth in this Regulation exists whereby reasonable care for which benefits authorized or reimbursed under the Basic Program before June 1, 1977, shall continue to be authorized even though the care would be excluded as a benefit under the custodial care limitations of the Regulation. Continuation of CHAMPUS benefits in such cases is limited as follows:

(1) Initial authorization or reimbursement before June 1, 1977. The initial CHAMPUS authorization or reimbursement for the care occurred before June 1, 1977; and,

(2) Continued care. The care has been continuous since the initial CHAMPUS authorization or reimbursement; and,

(3) Reasonable care. The care is reasonable. CHAMPUS benefits shall be continued for reasonable care up to the same level of benefits and for the same period of eligibility authorized or reimbursed before June 1, 1977. Care that is excessive or otherwise unreasonable will be reduced or eliminated from the continued care authorized under this exception.

13. Domiciliary care. The statute under which CHAMPUS operates also specifically excludes domiciliary care (refer to Chapter 2 of this Regulation for the definition of "Domiciliary Care").

a. Examples of domiciliary care situations. The following are examples of domiciliary care for which CHAMPUS benefits are not payable.

(1) Home care is not available. Institutionalization primarily because parents work, or extension of a hospital stay beyond what is medically necessary because the patient lives alone, are examples of domiciliary care provided because there is no other family member or other person available in the home.

(2) Home care is not suitable. Institutionalization of a child because a parent (or parents) is an alcoholic who is not responsible enough to care for the child, or because someone in the home has a contagious disease, are examples of domiciliary care being provided because the home setting is unsuitable.

(3) Family unwilling to care for a person in the home. A child who is difficult to manage may be placed in an institution, not because institutional care is medically necessary, but because the family does not want to handle him or her in the home. Such institutionalization would represent domiciliary care, that is, the family being unwilling to assume responsibility for the child.

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b. Benefits available in connection with a domiciliary care case. Should the beneficiary receive otherwise covered medical services or supplies while also being in a domiciliary care situation, CHAMPUS benefits are payable for those medical services or supplies, or both in the same manner as though the beneficiary resided in his or her own home. Such benefits would be cost-shared as though rendered to an outpatient.

c. General exclusion. Domiciliary care is institutionalization essentially to provide a substitute home--not because it is medically necessary for the beneficiary to be in the institution (although there may be conditions present that have contributed to the fact that domiciliary care is being rendered). CHAMPUS benefits are not payable for any costs or charges related to the provision of domiciliary care. While a substitute home or assistance may be necessary for the beneficiary, domiciliary care does not represent the kind of care for which CHAMPUS benefits can be provided.

14 CT scanning

a. Approved CT scan services. Benefits may be extended for medically necessary CT scans of the head or other anatomical regions of the body when all of the following conditions are met:

(1) The patient is referred for the diagnostic procedure by a physician.

(2) The CT scan procedure is consistent with the preliminary diagnosis or symptoms.

(3) Other noninvasive and less costly means of diagnosis have been attempted or are not appropriate.

(4) The CT scan equipment is licensed or registered by the appropriate state agency responsible for licensing or registering medical equipment that emits ionizing radiation.

(5) The CT scan equipment is operated under the general supervision and direction of a physician.

(6) The results of the CT scan diagnostic procedure are interpreted by a physician.

b. Review guidelines and criteria. The Director, OCHAMPUS, or a designee, will issue specific guidelines and criteria for CHAMPUS coverage of medically necessary head and body part CT scans.

15. Morbid obesity. The CHAMPUS morbid obesity benefit is limited to the gastric bypass, gastric stapling, or gastroplasty method.

a. Conditions for coverage. Payment may be extended for the gastric bypass, gastric stapling, or gastroplasty method only when one of the following conditions is met:

(1) The patient is 100 pounds over the ideal weight for height and bone structure and has an associated severe medical condition. These associated medical conditions are diabetes mellitus, hypertension, cholecystitis, narcolepsy, pickwickian syndrome (and other severe respiratory diseases), hypothalamic disorders, and severe arthritis of the weight-bearing joints.

(2) The patient is 200 percent or more of the ideal weight for height and bone structure. An associated medical condition is not required for this category.

(3) The patient has had an intestinal bypass or other surgery for obesity and, because of complications, requires a second surgery (a takedown). The surgeon in many cases, will do a gastric bypass, gastric stapling, or gastroplasty to help the patient avoid regaining the weight that was lost. In this situation, payment is authorized even though the patient's condition technically may not meet the definition of morbid obesity because of the weight that was already lost following the initial surgery.

b. Exclusions

(1) CHAMPUS payment may not be made for nonsurgical treatment of obesity or morbid obesity, for dietary control, or weight reduction.

(2) CHAMPUS payment may not be made for surgical procedures other than the gastric bypass, gastric stapling, or gastroplasty, even if morbid obesity is present.

16. Maternity care.

a. Benefit. The CHAMPUS Basic Program may share the cost of medically necessary services and supplies associated with maternity care which are not otherwise excluded by this Regulation. However, failure by a beneficiary to secure a required Nonavailability Statement (NAS) (DD Form 1251) as set forth in subsection A. 9. of this Chapter will waive that beneficiary's right to CHAMPUS cost-share of certain maternity care services and supplies.

b. Cost-share. Subject to applicable NAS requirements, maternity care cost-share shall be determined as follows:

(1) Inpatient cost-share formula applies to maternity care ending in childbirth in, or on the way to, a hospital inpatient childbirth unit, and for maternity care ending in a non-birth outcome not otherwise excluded by this Regulation.

(2) Ambulatory surgery cost-share formula applies to maternity care ending in childbirth in, or on the way to, a birthing center to which the beneficiary is admitted and from which the beneficiary has received prenatal care, or a hospital-based outpatient birthing room.

(3) Outpatient cost-share formula applies to maternity care which terminates in a planned childbirth at home.

(4) Otherwise covered medical services and supplies directly related to "Complications of Pregnancy," as defined in Chapter 2 will be cost-shared

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on the same basis as the related maternity care for a period not to exceed 42 days following termination of the pregnancy and thereafter cost-shared on the basis of the inpatient or outpatient status of the beneficiary when medically necessary services and supplies are received.

17. Biofeedback Therapy. Biofeedback therapy is a technique by which a person is taught to exercise control over a physiologic process occurring within the body. By using modern biomedical instruments the patient learns how a specific physiologic system within his body operates and how to modify the performance of this particular system.

a. Benefits provided. CHAMPUS benefits are payable for services and supplies in connection with electrothermal, electromyograph and electrodermal biofeedback therapy when there is documentation that the patient has undergone an appropriate medical evaluation, that their present condition is not responding to or no longer responds to other forms of conventional treatment, and only when provided as treatment for the following conditions:

(1) Adjunctive treatment for Raynaud's Syndrome.

(2) Adjunctive treatment for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, or incapacitating muscle spasm or weakness.

b. Limitations. Payable benefits include initial intake evaluation. Treatment following the initial intake evaluation is limited to a maximum of 20 inpatient and outpatient biofeedback treatments per calendar year.

c. Exclusions. Benefits are excluded for biofeedback therapy for the treatment of ordinary muscle tension states or for psychosomatic conditions. Benefits are also excluded for the rental or purchase of biofeedback equipment.

d. Provider requirements. A provider of biofeedback therapy must be a CHAMPUS-authorized provider. (Refer to CHAPTER 6, "Authorized Providers.") If biofeedback treatment is provided by other than a physician, the patient must be referred by a physician.

e. Implementation Guidelines. The Director, OCHAMPUS, shall issue guidelines as are necessary to implement the provisions of this paragraph.

8. Cardiac Rehabilitation. Cardiac rehabilitation is the process by which individuals are restored to their optimal physical, medical and psychological status, after a cardiac event. Cardiac rehabilitation is often divided into three phases. Phase I begins during inpatient hospitalization and is managed by the patient's personal physician. Phase II is a medically supervised outpatient program which begins following discharge. Phase III is a lifetime maintenance program emphasizing continuation of physical fitness with periodic followup. Each phase includes an exercise component, patient education, and risk factor modification. There may be considerable variation in program components, intensity and duration.

a. Benefits Provided. CHAMPUS benefits are available on an inpatient or outpatient basis for services and supplies provided in connection with a cardiac rehabilitation program when ordered by a physician and provided as treatment for patients who have experienced the following cardiac events within the preceding twelve (12) months:

- (1) Myocardial Infarction.
- (2) Coronary Artery Bypass Graft.
- (3) Coronary Angioplasty.
- (4) Percutaneous Transluminal Coronary Angioplasty.
- (5) Chronic Stable Angina (see limitations below).

b. Limitations. Payable benefits include separate allowance for the initial evaluation and testing. Outpatient treatment following the initial intake evaluation and testing is limited to a maximum of thirty-six (36) sessions per cardiac event, usually provided 3 sessions per week for twelve weeks. Patient's diagnosed with chronic stable angina are limited to one treatment episode (36 sessions) in a calendar year.

c. Exclusions. Phase III cardiac rehabilitation lifetime maintenance programs performed at home or in medically unsupervised settings are not covered.

d. Providers. A provider of cardiac rehabilitation services must be a CHAMPUS authorized hospital. (Refer to Chapter 6, "Authorized Providers.") All cardiac rehabilitation services must be ordered by a physician.

e. Payment. Payment for outpatient treatment will be based on an all inclusive allowable charge per session. Inpatient treatment will be paid based upon the reimbursement system in place for the hospital where the services are rendered.

f. Implementation Guidelines: The Director of OCHAMPUS shall issue guidelines as are necessary to implement the provisions of this paragraph.

F. BENEFICIARY OR SPONSOR LIABILITY

1. General. As stated in the introductory paragraph to this chapter, the Basic Program is essentially a supplemental program to the Uniformed Services direct medical care system. To encourage use of the Uniformed Services direct medical care system wherever its facilities are available and appropriate, the Basic Program benefits are designed so that it is to the financial advantage of a CHAMPUS beneficiary or sponsor to use the direct medical care system. When medical care is received from civilian sources, a CHAMPUS beneficiary is responsible for payment of certain deductible and cost-sharing amounts in connection with otherwise covered services and supplies. By statute, this joint financial responsibility between the beneficiary or sponsor and CHAMPUS is more favorable for dependents of active duty members than for other classes of beneficiaries.

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2. Dependents of active duty members of the Uniformed Services. CHAMPUS beneficiary or sponsor liability set forth for dependents of active duty members is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. A CHAMPUS beneficiary or sponsor is responsible for the payment of the first \$50 of the CHAMPUS-determined allowable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year. However, when such outpatient services are provided to more than one beneficiary member

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of a family during the same fiscal year, the aggregate outpatient deductible amount paid by any two or more beneficiary members of the family who submit claims may not exceed \$100 during any fiscal year.

(1) In any one fiscal year if only one beneficiary member of a family files a claim (regardless of the number of beneficiary members actually in the family), that beneficiary member is required only to satisfy a \$50 annual fiscal year deductible for outpatient services or supplies as described in paragraph F.2.a., above.

(2) In any one fiscal year if two or more beneficiary members of a family file claims, the total amount of which is less than \$100 but none of the beneficiary members submit a claim for over \$50 dollars, no CHAMPUS benefits are payable for otherwise covered outpatient services or supplies provided such beneficiary members during that particular fiscal year.

(3) For any family the outpatient deductible amounts will be applied sequentially as the CHAMPUS claims are submitted.

(4) If the fiscal year outpatient deductible has been met by a beneficiary (\$50) or a family (\$100 aggregate) through the submission of a claim or claims to a CHAMPUS fiscal intermediary in another geographic location from the location where a current claim is being submitted, the beneficiary or sponsor must obtain a deductible certificate from the CHAMPUS fiscal intermediary where the applicable beneficiary or family fiscal year deductible was met. Such deductible certificate must be attached to the current claim being submitted for benefits. Failure to obtain a deductible certificate under such circumstances will result in a second beneficiary or family fiscal year deductible being applied. However, this second deductible may be reimbursed once appropriate documentation, as described in this subparagraph F.2.a.(4), is supplied to the CHAMPUS fiscal intermediary applying the second deductible (refer to section A. of Chapter 7 of this Regulation).

b. Inpatient cost-sharing. Dependents of active duty members of the Uniformed Services or their sponsors are responsible for the payment of the first \$25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider (refer to Chapter 6 of this Regulation), or the amount the beneficiary or sponsor would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater.

NOTE: The Secretary of Defense (after consulting with the Secretary of Health and Human Services and the Secretary of Transportation) prescribes the fair charges for inpatient hospital care provided through Uniformed Services medical facilities. This determination is made each fiscal year.

(1) Inpatient cost-sharing payable with each separate inpatient admission. A separate cost-sharing amount (as described in this subsection F.2.) is payable for each inpatient admission to a hospital or other authorized institution, regardless of the purpose of the admission (such as medical or surgical), regardless of the number of times the beneficiary is admitted.

and regardless of whether or not the inpatient admissions are for the same or related conditions; except that successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the inpatient cost-share payable, provided not more than 60 days have elapsed between the successive admissions. However, notwithstanding this provision, all admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions (refer to section B. of this chapter).

(2) Multiple family inpatient admissions. A separate cost-sharing amount is payable for each inpatient admission, regardless of whether or not two or more beneficiary members of a family are admitted at the same time or from the same cause (such as an accident). A separate beneficiary inpatient cost-sharing amount must be applied for each separate admission on each beneficiary member of the family.

(3) Newborn patient in his or her own right. When a newborn infant remains as an inpatient in his or her own right (usually after the mother is discharged), the newborn child becomes the beneficiary and patient and the extended inpatient stay becomes a separate inpatient admission. In such a situation, a new, separate inpatient cost-sharing amount is applied. If a multiple birth is involved (such as twins or triplets) and two or more newborn infants become patients in their own right, a separate inpatient cost-sharing amount must be applied to the inpatient stay for each newborn child who has remained as an inpatient in his or her own right.

c. Outpatient cost-sharing. Dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of 20 percent of the CHAMPUS-determined allowable cost or charge beyond the annual fiscal year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

d. Ambulatory surgery. Notwithstanding the above provisions pertaining to outpatient cost-sharing, dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of \$25 for surgical care that is authorized and received while in an outpatient status and that has been designated in guidelines issued by the Director, OCHAMPUS, or a designee.

3. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees. CHAMPUS beneficiary liability set forth for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. The annual fiscal year deductible for otherwise covered outpatient services or supplies provided retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees is identical to the annual fiscal year outpatient deductible applicable to dependents of active duty members (refer to paragraph F.2.a. of this chapter).

b. Inpatient cost-sharing. Cost-sharing amounts for inpatient services shall be as follows:

(1) Services subject to the CHAMPUS DRG-based payment system. The cost-share shall be the lesser of an amount calculated by multiplying a per diem amount for each day of the hospital stay except the day of discharge or 25 percent of the hospital's billed charges. The per diem amount shall be calculated so that total cost-sharing amounts for these beneficiaries is equivalent to 25 percent of the CHAMPUS-determined allowable costs for covered services or supplies provided on an inpatient basis by authorized providers. The per diem amount shall be published annually by CHAMPUS.

(2) Services subject to the mental health per diem payment system. The cost-share is dependent upon whether the hospital is paid a hospital-specific per diem or a regional per diem under the provisions of subsection A.2. of Chapter 14. With respect to care paid for on the basis of a hospital-specific per diem, the cost-share shall be 25% of the hospital-specific per diem amount. For care paid for on the basis of a regional per diem, the cost share shall be the lower of a fixed daily amount or 25% of the hospital's billed charges. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25 percent of total payments under the mental health per diem payment system. This fixed daily amount shall be updated annually and published in the Federal Register along with the per diems published pursuant to subparagraph A.2.d.(2) of Chapter 14.

(3) Other services. For services exempt from the CHAMPUS DRG-based payment system and the CHAMPUS mental health per diem payment system and services provided by institutions other than hospitals, the cost-share shall be 25% of the CHAMPUS-determined allowable charges.

c. Outpatient cost-sharing. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees are responsible for payment of 25 percent of the CHAMPUS-determined allowable costs or charges beyond the annual fiscal year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

4. Former spouses. CHAMPUS beneficiary liability set forth for former spouses eligible under the provisions of paragraph B.2.b. of Chapter 3 is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. An eligible former spouse is responsible for the payment of the first \$50 of the CHAMPUS-determined reasonable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year. The former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of any CHAMPUS-eligible children.

b. Inpatient cost-sharing. Eligible former spouses are responsible for the payment of cost-sharing amounts the same as those required for

retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.

c. Outpatient cost-sharing Eligible former spouses are responsible for payment of 25 percent of the CHAMPUS-determined reasonable costs or charges beyond the annual fiscal year deductible amount for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

5. Cost-Sharing under the Military-Civilian Health Services Partnership Program. Cost-sharing is dependent upon the type of partnership program entered into, whether external or internal. (See section P. of Chapter 1, for general requirements of the Military-Civilian Health Services Partnership Program.)

a. External Partnership Agreement. Authorized costs associated with the use of the civilian facility will be financed through CHAMPUS under the normal cost-sharing and reimbursement procedures applicable under CHAMPUS.

b. Internal Partnership Agreement. Beneficiary cost-share under internal agreements will be the same as charges prescribed for care in military treatment facilities.

6. Amounts over CHAMPUS-determined allowable costs or charges. It is the responsibility of the CHAMPUS fiscal intermediary to determine allowable costs for services and supplies provided by hospitals and other institutions and allowable charges for services and supplies provided by physicians, other individual professional providers, and other providers. Such CHAMPUS-determined allowable costs or charges are made in accordance with the provisions of Chapter 14. All CHAMPUS benefits, including calculation of the CHAMPUS or beneficiary cost-sharing amounts, are based on such CHAMPUS-determined allowable costs or charges. The effect on the beneficiary when the billed cost or charge is over the CHAMPUS-determined allowable amount is dependent upon whether or not the applicable claim was submitted on a participating basis on behalf of the beneficiary or submitted directly by the beneficiary on a nonparticipating basis and on whether the claim is for inpatient hospital services subject to the CHAMPUS DRG-based payment system. This provision applies to all classes of CHAMPUS beneficiaries.

NOTE: When the provider "forgives" or "waives" any beneficiary liability, such as amounts applicable to the annual fiscal year deductible for outpatient services or supplies, or the inpatient or outpatient cost-sharing as previously set forth in this section, the CHAMPUS-determined allowable charge or cost allowance (whether payable to the CHAMPUS beneficiary or sponsor, or to a participating provider) shall be reduced by the same amount.

a. Participating provider. Under CHAMPUS, authorized professional providers and institutional providers other than hospitals have the option of participating on a claim-by-claim basis. Participation is required for inpatient claims only for hospitals which are Medicare-participating providers. Hospitals which are not Medicare-participating but which are subject to the CHAMPUS DRG-based payment system in subsection A.1. of Chapter 14 must sign agreements to participate

on all CHAMPUS inpatient claims in order to be authorized providers under CHAMPUS. All other hospitals may elect to participate on a claim-by-claim basis. Participating providers must indicate participation by signing the appropriate space on the applicable CHAMPUS claim form and submitting it to the appropriate CHAMPUS fiscal intermediary. In the case of an institution or medical supplier, the claim must be signed by an official having such authority. This signature certifies that the provider has agreed to accept the CHAMPUS-determined allowable charge or cost as payment in full for the medical services and supplies listed on the specific claim form, and further has agreed to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing amount paid by or on behalf of the beneficiary as full payment for the covered medical services or supplies. Therefore, when costs or charges are submitted on a participating basis, the patient is not obligated to pay any amounts disallowed as being over the CHAMPUS-determined allowable cost or charge for authorized medical services or supplies.

b. Nonparticipating providers. Nonparticipating providers are those providers who do not agree on the CHAMPUS claim form to participate and thereby do not agree to accept the CHAMPUS-determined allowable costs or charges as the full charge. For otherwise covered services and supplies provided by such nonparticipating CHAMPUS providers, payment is made directly to the beneficiary or sponsor and the beneficiary is liable under applicable law for any amounts over the CHAMPUS-determined allowable costs or charges. CHAMPUS shall have no responsibility for any amounts over allowable costs or charges as determined by CHAMPUS.

7. [Reserved]

8. Cost-sharing for services provided under special discount arrangements.

a. General rule. With respect to services determined by the Director, OCHAMPUS (or designee) to be covered by Chapter 14, section I., the Director, OCHAMPUS (or designee) has authority to establish, as an exception to the cost-sharing amount normally required pursuant to this chapter, a different cost-share amount that appropriately reflects the application of the statutory cost-share to the discount arrangement.

b. Specific applications. The following are examples of applications of the general rule; they are not all inclusive.

(1) In the case of services provided by individual health care professionals and other noninstitutional providers, the cost-share shall be the usual percentage of the CHAMPUS allowable charge determined under Chapter 14, section I.

(2) In the case of services provided by institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under Chapter 14, section A.1. or per-diem amount under Chapter 14, section A.2.), if the discount rate is lower than the pre-set rate, the cost-share amount that would apply for a beneficiary other than an active duty dependent pursuant to the normal pre-set rate would be reduced by the same percentage by which the pre-set rate was reduced in setting the discount rate.

G. EXCLUSIONS AND LIMITATIONS

In addition to any definitions, requirements, conditions, or limitations enumerated and described in other chapters of this Regulation, the following specifically are excluded from the Basic Program:

1. Not medically or psychologically necessary. Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or injury, for the diagnosis and treatment of pregnancy, or for well-baby care.
2. Unnecessary diagnostic tests. X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms.
3. Institutional level of care. Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.
4. Diagnostic admission. Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.

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NOTE: If it is determined that the diagnostic x-ray, laboratory, and pathological services and machine tests performed during such admission were medically necessary and would have been covered if performed on an outpatient basis, CHAMPUS benefits may be extended for such diagnostic procedures only, but cost-sharing will be computed as if performed on an outpatient basis.

5. Unnecessary postpartum inpatient stay, mother or newborn. Postpartum inpatient stay of a mother for purposes of staying with the newborn infant (usually primarily for the purpose of breast feeding the infant) when the infant (but not the mother) requires the extended stay; or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.

6. Therapeutic absences. Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by the Director, OCHAMPUS, or a designee. For cost-sharing provisions refer to Chapter 14, paragraph F.3.

7. Custodial care. Custodial care regardless of where rendered, except as otherwise specifically provided in paragraphs E.12.b., E.12.c. and E.12.d. of this chapter.

8. Domiciliary care. Inpatient stays primarily for domiciliary care purposes.

9. Rest or rest cures. Inpatient stays primarily for rest or rest cures.

10. Amounts above allowable costs or charges. Costs of services and supplies to the extent amounts billed are over the CHAMPUS determined allowable cost or charge, as provided for in Chapter 14.

11. No legal obligation to pay, no charge would be made. Services or supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary or sponsor was not eligible under CHAMPUS; or whenever CHAMPUS is a secondary payer for claims subject to the CHAMPUS DRG-based payment system, amounts, when combined with the primary payment, which would be in excess of charges (or the amount the provider is obligated to accept as payment in full, if it is less than the charges).

12. Furnished without charge. Services or supplies furnished without charge.

13. Furnished by local, state, or Federal Government. Services and supplies paid for, or eligible for payment, directly or indirectly by a local, state, or Federal Government, except as provided under CHAMPUS, or by government hospitals serving the general public, or medical care provided by a Uniformed Service medical care facility, or benefits provided under title XIX of the Social Security Act (Medicaid) (reference (h)) (refer to Chapter 8 of this Regulation).

14. Study, grant, or research programs. Services and supplies provided as a part of or under a scientific or medical study, grant, or research program.

15. Not in accordance with accepted standards, experimental or investigational. Services and supplies not provided in accordance with accepted professional medical standards; or related to essentially experimental or investigational procedures or treatment regimens.

16. Immediate family, household. Services or supplies provided or prescribed by a member of the beneficiary's immediate family, or a person living in the beneficiary's or sponsor's household.

17. Double coverage. Services and supplies that are (or are eligible to be) payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare (refer to Chapter 8 of this Regulation).

18. Nonavailability Statement required. Services and supplies provided under circumstances or in geographic locations requiring a Nonavailability Statement (DD Form 1251), when such a statement was not obtained.

19. Preauthorization required. Services or supplies which require preauthorization if preauthorization was not obtained. Services and supplies which were not provided according to the terms of the preauthorization. The Director, OCHAMPUS, or a designee, may grant an exception to the requirement for preauthorization if the services otherwise would be payable except for the failure to obtain preauthorization.

20. Psychoanalysis or psychotherapy, part of education. Psychoanalysis or psychotherapy provided to a beneficiary or any member of the immediate family that is credited towards earning a degree or furtherance of the education or training of a beneficiary or sponsor, regardless of diagnosis or symptoms that may be present.

21. Runaways. Inpatient stays primarily to control or detain a runaway child, whether or not admission is to an authorized institution.

22. Services or supplies ordered by a court or other government agency. Services or supplies, including inpatient stays, directed or agreed to by a court or other governmental agency. However, those services and supplies (including inpatient stays) that otherwise are medically or psychologically necessary for the diagnosis or treatment of a covered condition and that otherwise meet all CHAMPUS requirements for coverage are not excluded.

23. Work-related (occupational) disease or injury. Services and supplies required as a result of occupational disease or injury for which any benefits are payable under a worker's compensation or similar law, whether or not such benefits have been applied for or paid; except if benefits provided under such laws are exhausted.

24. Cosmetic, reconstructive, or plastic surgery. Services and supplies in connection with cosmetic, reconstructive, or plastic surgery except as specifically provided in subsection E.8. of this chapter.

25. Surgery, psychological reasons. Surgery performed primarily for psychological reasons (such as psychogenic).

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26. Electrolysis.

27. Dental care. Dental care or oral surgery, except as specifically provided in subsection E.10. of this chapter.

28. Obesity, weight reduction. Services and supplies related to obesity or weight reduction whether surgical or nonsurgical; wiring of the jaw or any procedure of similar purpose, regardless of the circumstances under which performed; except that benefits may be provided for the gastric bypass, gastric stapling, or gastroplasty procedures in connection with morbid obesity as provided in subsection E.15. of this chapter.

29. Transsexualism or such other conditions as gender dysphoria. Services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in subsection E.7. of this chapter.

30. Therapy or counseling for sexual dysfunctions or sexual inadequacies. Sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy for mental disorders involving sex deviations (e.g., transvestic fetishism), or other similar services, and any supplies provided in connection with therapy for sexual dysfunctions or inadequacies.

31. Corns, calluses, and toenails. Removal of corns or calluses or trimming of toenails and other routine podiatry services, except those required as a result of a diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

32. Dyslexia.

33. Surgical sterilization, reversal. Surgery to reverse surgical sterilization procedures.

34. Noncoital reproductive procedures including artificial insemination, in-vitro fertilization, gamete intrafallopian transfer and all other such reproductive technologies. Services and supplies related to artificial insemination (including semen donors and semen banks), in-vitro fertilization, gamete intrafallopian transfer and all other noncoital reproductive technologies.

35. Nonprescription contraceptives.

36. Tests to determine paternity or sex of a child. Diagnostic tests to establish paternity of a child; or tests to determine sex of an unborn child.

37. Preventive care. Preventive care, such as routine, annual, or employment requested physical examinations; routine screening procedures; immunizations; except that the following are not excluded:

a. Well-baby care, including newborn examination. Phenylketonuria (PKU) testing and newborn circumcision.

b. Rabies shots.

c. Tetanus shot following an accidental injury.

d. Rh immune globulin.

e. Genetic tests as specified in paragraph E.3.b. of this chapter.

f. Immunizations and physical examinations provided when required in the case of dependents of active duty military personnel who are traveling outside the United States as a result of an active member's duty assignment and such travel is being performed under orders issued by a Uniformed Service.

38. Chiropractors and naturopaths. Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider.

39. Counseling. Educational counseling, nutritional counseling, vocational counseling, and counseling for socio-economic purposes. Counseling services that are not medically necessary in the treatment of a diagnosed medical condition, e.g., diabetic self-education programs, stress management, life style modification, etc. Services provided by a marriage, family, pastoral or mental health counselor in the treatment of a mental disorder are covered only as specifically provided in Chapter 6. Services provided by alcoholism rehabilitation counselors are covered only when rendered in a CHAMPUS-authorized alcohol rehabilitation facility and only when the cost of those services is included in the facility's CHAMPUS-determined allowable cost-rate.

40. Acupuncture. Acupuncture, whether used as a therapeutic agent or as an anesthetic.

41. Hair transplants, wigs, or hairpieces

NOTE: In accordance with Section 744 of the DoD Appropriation Act for 1981 (reference (c)), CHAMPUS coverage for wigs or hairpieces is permitted effective December 15, 1980, under the conditions listed below. Continued availability of benefits will depend on the language of the annual DoD Appropriation Acts.

a. Benefits provided. Benefits may be extended, in accordance with the CHAMPUS-determined allowable charge, for one wig or hairpiece per beneficiary (lifetime maximum) when the attending physician certifies that alopecia has resulted from treatment of a malignant disease and the beneficiary certifies that a wig or hairpiece has not been obtained previously through the U.S. Government (including the Veterans Administration).

b. Exclusions. The wig or hairpiece benefit does not include coverage for the following:

(1) Alopecia resulting from conditions other than treatment of malignant disease.

(2) Maintenance, wig or hairpiece supplies, or replacement of the wig or hairpiece.

(3) Hair transplants or any other surgical procedure involving the attachment of hair or a wig or hairpiece to the scalp.

(4) Any diagnostic or therapeutic method or supply intended to encourage hair regrowth.

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42. Education or training. Self-help, academic education or vocational training services and supplies, unless the provisions of Chapter 4, paragraph B.1.e., relating to general or special education, apply.

43. Exercise/Relaxation/Comfort Devices. Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

44. Exercise. General exercise programs, even if recommended by a physician and regardless of whether or not rendered by an authorized provider. In addition, passive exercises and range of motion exercises also are excluded, except when prescribed by a physician and rendered by a physical therapist concurrent to, and as an integral part of, a comprehensive program of physical therapy.

45. Audiologist, speech therapist. Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of treatment addressed to the physical defect itself and not to any educational or occupational deficit.

46. Vision care. Eye exercises or visual training (orthoptics).

47. Eye and hearing examinations. Eye and hearing examinations except as specifically provided in paragraph C.2.p. of this chapter or except when rendered in connection with medical or surgical treatment of a covered illness or injury. Vision and hearing screening in connection with well-baby care is not excluded.

48. Prosthetic devices. Prostheses, except artificial limbs and eyes, or if an item is inserted surgically in the body as an integral part of a surgical procedure. All dental prostheses are excluded, except for those specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

49. Orthopedic shoes. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes, or regular shoes later built up.

50. Eyeglasses. Eyeglasses, spectacles, contact lenses, or other optical devices, except as specifically provided under subsection E.6. of this chapter.

51. Hearing aids. Hearing aids or other auditory sensory enhancing devices.

52. Telephonic services. Services or advice rendered by telephone or other telephonic device, including remote monitoring, except for transtelephonic monitoring of cardiac pacemakers.

53. Air conditioners, humidifiers, dehumidifiers, and purifiers.

54. Elevators or chair lifts.

55. Alterations. Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.

56. Clothing. Items of clothing or shoes, even if required by virtue of an allergy (such as cotton fabric as against synthetic fabric and vegetable dyed shoes).

57. Food, food substitutes. Food, food substitutes, vitamins, or other nutritional supplements, including those related to prenatal care.

58. Enuresis. Enuretic devices; enuretic conditioning programs.

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60. Autopsy and postmortem.

61. Camping. All camping even though organized for a specific therapeutic purpose (such as diabetic camp or a camp for emotionally disturbed children), and even though offered as a part of an otherwise covered treatment plan or offered through a CHAMPUS-approved facility.

62. Housekeeper, companion. Housekeeping, homemaker, or attendant services; sitter or companion.

63. Noncovered condition, unauthorized provider. All services and supplies (including inpatient institutional costs) related to a noncovered condition or treatment, or provided by an unauthorized provider.

64. Comfort or convenience. Personal, comfort, or convenience items such as beauty and barber services, radio, television, and telephone.

65. "Stop smoking" programs. Services and supplies related to "stop smoking" regimens.

66. Megavitamin psychiatric therapy, orthomolecular psychiatric therapy.

67. Transportation. All transportation except by ambulance, as specifically provided under section D. of this chapter, and except as authorized in subsection E.5. of this chapter.

68. Travel. All travel even though prescribed by a physician and even if its purpose is to obtain medical care, except as specified in subsection A.6. of this chapter in connection with a CHAMPUS-required physical examination.

69. Institutions. Services and supplies provided by other than a hospital, unless the institution has been approved specifically by OCHAMPUS. Nursing homes, intermediate care facilities, halfway houses, homes for the aged, or institutions of similar purpose are excluded from consideration as approved facilities under the Basic Program.

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NOTE: In order to be approved under CHAMPUS, an institution must, in addition to meeting CHAMPUS standards, provide a level of care for which CHAMPUS benefits are payable.

70. Supplemental diagnostic services. Diagnostic services including clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results performed by civilian providers at the request of the attending Uniformed Service medical department physician (active duty or civil service).

71. Supplemental consultations. Consultations provided by civilian providers at the request of the attending Uniformed Services medical department physician (active duty or civil service).

72. Inpatient mental health services. More than 60 days of inpatient mental health services in any calendar year, unless additional coverage is granted by the Director, OCHAMPUS, or a designee, in accordance with paragraph B.5.i. of this chapter. This exclusion does not apply to services provided under the provisions of Chapter 5 of this Regulation; services provided on less than a 24-hour-a-day basis; or services provided in a CHAMPUS-authorized residential treatment center that meets the requirements of paragraph B.4.e. of Chapter 6, of this Regulation.

73. Not specifically listed. Services and supplies not specifically listed as a benefit in this Regulation. This exclusion is not intended to preclude extending benefits for those services or supplies specifically determined to be covered within the intent of this Regulation by the Director, OCHAMPUS, or a designee, even though not otherwise listed.

NOTE: The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not listed specifically as an exclusion.

H. Payment and liability for certain potentially excludable services under the Peer Review Organization program.

1. Applicability. This section provides special rules that apply only to services retrospectively determined under the Peer Review Organization (PRO) program (operated pursuant to Chapter 15) to be potentially excludable (in whole or in part) from the Basic Program under section G. of this chapter. Services may be excluded by reason of being not medically necessary (subsection G.1.) at an inappropriate level (subsection G.3.) custodial care (subsection G.7.) or other reason relative to reasonableness, necessity or appropriateness (which services shall throughout the remainder of this section, be referred to as "not medically necessary"). (Also throughout the remainder of the section, "services" includes items and "provider" includes supplier.) This section does not apply to coverage determinations made by OCHAMPUS or the fiscal intermediaries which are not based on medical necessity determinations made under the PRO program.

2. Payment for certain potentially excludable expenses. Services determined under the PRO program to be potentially excludable by reason of the exclusions in

section G. of this chapter for not medically necessary services will not be determined to be excludable if neither the beneficiary to whom the services were provided nor the provider (institutional or individual) who furnished the services knew, or could reasonably have been expected to know, that the services were subject to those exclusions. Payment may be made for such services as if the exclusions did not apply.

3. Liability for certain excludable services. In any case in which items or services are determined excludable by the PRO program by reason of being not medically necessary and payment may not be made under subsection H.2., above because the requirements of subsection H.2. are not met, the beneficiary may not be held liable (and shall be entitled to a full refund from the provider of the amount excluded and any cost-share amount already paid) if:

a. The beneficiary did not know and could not reasonably have been expected to know that the services were excludable by reason of being not medically necessary; and

b. The provider knew or could reasonably have been expected to know that the items or services were excludable by reason of being not medically necessary.

4. Criteria for determining that beneficiary knew or could reasonably have been expected to have known that services were excludable. A beneficiary who receives services excludable by reason of being not medically necessary will be found to have known that the services were excludable if the beneficiary has been given written notice that the services were excludable or that similar or comparable services provided on a previous occasion were excludable and that notice was given by the OCHAMPUS, CHAMPUS PRO or fiscal intermediary, a group or committee responsible for utilization review for the provider, or the provider who provided the services.

5. Criteria for determining that provider knew or could reasonably have been expected to have known that services were excludable. An institutional or individual provider will be found to have known or been reasonably expected to have known that services were excludable under this section under any one of the following circumstances:

a. The PRO or fiscal intermediary had informed the provider that the services provided were excludable or that similar or reasonably comparable services were excludable.

b. The utilization review group or committee for an institutional provider or the beneficiary's attending physician had informed the provider that the services provided were excludable.

c. The provider had informed the beneficiary that the services were excludable.

d. The provider had received written materials, including notices, manual issuances, bulletins, guides, directives, or other materials, providing notification of PRO screening criteria specific to the condition of the beneficiary. Attending physicians who are members of the medical staff

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of an institutional provider will be found to have also received written materials provided to the institutional provider.

e. The services that are at issue are the subject of what are generally considered acceptable standards of practice by the local medical community.

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CHAPTER 5

PROGRAM FOR THE HANDICAPPED (PFTH)

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CHAPTER 5
PROGRAM FOR THE HANDICAPPED (PFTH)

A. GENERAL

The PFTH is essentially a program of financial assistance for military personnel on active duty whose spouses or children may be moderately or severely mentally retarded or seriously physically handicapped and in need of specialized institutional care, training, or rehabilitation, and the required services are not available from public institutions or agencies. The PFTH was established by Congress to be a source of financial assistance when an active duty member's handicapped dependents, by virtue of residency laws, have been excluded from appropriate publicly operated programs or institutions for the handicapped. There is, therefore, a requirement that all local resources must be considered and those determined as adequate be utilized first, before an application for coverage under the PFTH will be acted on by the Director, OCHAMPUS, or a designee. There is a further requirement that all institutional care otherwise authorized be provided in not-for-profit CHAMPUS-approved institutions. Coverage for any services or supplies under the PFTH requires prior approval.

1. Physical or mental examinations. The Director, OCHAMPUS, or a designee, may request a beneficiary to submit to one or more appropriate medical (including psychiatric) examinations to determine the beneficiary's entitlement to benefits for which application has been made or for otherwise authorized services and supplies required in the proposed management plan for the handicapped dependent. When such an examination has been requested, CHAMPUS will withhold payment of any pending claim or claims or preauthorization requests on that particular beneficiary. If the beneficiary or sponsor does not agree to the requested examination, or unless prevented by a medical reason acceptable to CHAMPUS, the examination is not performed within 90 days of the initial request, all pending claim or claims for services and supplies will be denied. A denial of payments for such services or supplies provided before and related to the request for a physical examination is not subject to reconsideration. The cost of the examination or examinations will be at the expense of CHAMPUS (including any related beneficiary transportation costs). The examination or examinations may be performed by a physician or physicians in a Uniformed Services medical facility or by an appropriate civilian physician, as determined and selected by the Director, OCHAMPUS, or a designee, who is responsible for making such arrangements as are necessary.

2. Right to information. As a condition precedent to the provision of benefits hereunder, OCHAMPUS or CHAMPUS fiscal intermediaries shall be entitled to receive information from a physician or hospital or other person, institution, or organization (including a local, state, or Federal Government agency) providing services or supplies to the beneficiary for which claims or requests for approval for benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, examination, diagnosis of, treatment rendered, or services and supplies furnished to, a beneficiary and shall be necessary for the accurate and efficient administration of CHAMPUS benefits. In addition, before a determination on a request for preauthorization or claim of benefits is made, a beneficiary or sponsor must provide particular additional information relevant to the requested determination, when necessary. The recipient of such information shall in every

case hold such records confidential except when (a) disclosure of such information is authorized specifically by the beneficiary; (b) disclosure is necessary to permit authorized governmental officials to investigate and prosecute criminal actions; or (c) disclosure is authorized or required specifically under the terms of the Privacy or Freedom of Information Acts (references (i), (j), and (k)) (refer to section M. of Chapter 1 of this Regulation). For the purposes of determining the applicability of and implementing the provisions of chapters 8, 11 and 12, or any provision of similar purpose of any other medical benefits coverage or entitlement, OCHAMPUS or CHAMPUS fiscal intermediaries, without consent or notice to any beneficiary or sponsor, may release to any insurance company or other organization, government agency, provider, or other entity any information with respect to any beneficiary when such release constitutes a routine use duly published in the Federal Register in accordance with the Privacy Act (reference (k)). Before a beneficiary's or sponsor's claim of benefits will be adjudicated, the beneficiary or sponsor must furnish to CHAMPUS that information which reasonably may be expected to be in his or her possession and that is necessary to make the benefit determination. Failure to provide the requested information may result in denial of the claim.

3. Timely filing of claims. All claims submitted for benefits under this chapter must be filed with the appropriate CHAMPUS fiscal intermediary no later than December 31 of the calendar year following the one in which the covered service or supply was provided. Failure to file a claim timely automatically waives all rights to any benefits for otherwise covered services or supplies (refer to Chapter 7 of this Regulation).

4. Eligibility for benefits

a. Eligibility criteria. Eligibility criteria for CHAMPUS generally are contained in Chapter 3 of this Regulation. However, coverage under the PFTH includes and is further limited to:

(1) The dependents, as defined in Chapter 3 but excluding former spouses, of a member of one of the Uniformed Services who is under call or order to active duty that does not specify a period of 30 days or less, who are moderately or severely mentally retarded or who have a serious physical handicap; or

(2) The dependents of a deceased active duty service member who died after January 1, 1967, while eligible for receipt of hostile fire pay or from a disease or injury incurred while eligible for such pay, who are under 21 years of age, and who otherwise meet the criteria of subparagraph A.4.a.(1), above, and were receiving benefits under the PFTH at the time of said member's death.

b. Sponsor ceases to be active duty member. When the sponsor ceases to be an active duty member because of death, benefits under the PFTH may be continued through the last day of the calendar month following the month in which the sponsor's death occurred. When the sponsor ceases to be an active duty member for any other reason, such as retirement, separation, or deserter status, benefits under the PFTH cease as of 12:01 a.m. of the day following the day the status of the sponsor changes. Exception is made only for those spouses and children under 21 years of age of deceased members

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qualifying for continued benefits under the provisions of subparagraph A.4.a.(2), above. Any support or aid for the handicapped dependent after CHAMPUS benefits cease is the responsibility of the sponsor (or parent or guardian).

c. Scope of benefits. Subject to the conditions and limitations set forth in this Regulation, the PFTH provides financial assistance toward the purchase of services or supplies necessary for the following:

- (1) Diagnosis.
- (2) Inpatient, outpatient, and home treatment.
- (3) Training, rehabilitation, and special education.
- (4) Institutional care in private not-for-profit or public and state institutions and facilities.
- (5) When appropriate, transportation to and from such institutions and facilities.

B. COST-SHARING

The sponsor is required to pay a portion of the costs for each month in which the dependent receives benefits under the PFTH. The amount the sponsor pays is based upon the pay grade. The amounts required of members in each pay grade are as follows:

<u>Member's Pay Grade</u>	<u>Share Amount (dollars)</u>
E-1 through E-5	25
E-6	30
E-7 and O-1	35
E-8 and O-2	40
E-9, W-1, W-2, and O-3	45
W-3, W-4, and O-4	50
O-5	65
O-6	75
O-7	100
O-8	150
O-9	200
O-10	250

Except as specifically set forth in subsection B.3., below, the Government's share of the cost of any benefits provided under the PFTH cannot exceed \$1,000 per month. Any amount remaining after the Government's maximum share has been reached is again the responsibility of the active duty member. In ascertaining the total charges against which the sponsor's and the Government's shares will be computed, certain considerations are made:

1. Charges or costs must be reasonable. The charges or costs must be reasonable for the services or supplies provided. The cost-share computations will be made on the amount determined to be allowable under the method used in the operation of the Basic Program (refer to Chapter 6 of this Regulation) and equivalent to a monthly billing unit.

2. CHAMPUS share limit. The CHAMPUS share of the allowable charges or costs of all benefits provided the handicapped beneficiary in a given month will not exceed \$1,000 per month, except when there are two or more handicapped dependents in the same family as described in subsection B.3., below.

3. Two or more handicapped dependents. When an active duty member has two or more dependents incurring expenses in a given month, the active duty member's monthly obligation will not be greater than he or she would be required to pay if he or she had but one such dependent receiving benefits under the PFTH. Such active duty member will be charged on the basis of the handicapped dependent incurring the least expense under the PFTH in any given month. The active duty member is obligated, however, to pay at least the amount indicated for his or her applicable pay grade shown in this section B., above. When the cost for one dependent is less than the amount shown for the applicable pay grade, the active duty member is obligated to pay such additional amount as is required to meet the cost for his or her pay grade towards satisfying the bill of the second dependent receiving benefits under the PFTH.

4. No prepayment of services. In no case will payment be made in advance for services not yet rendered.

5. Absence from an institution, cost-sharing implications. As a general rule, CHAMPUS will not cost-share any costs incurred during a period the handicapped dependent is absent from an institution with the following exceptions:

a. Illness or injury requiring hospitalization. When the handicapped dependent requires hospitalization, benefits under the PFTH may be continued up to the last day of the calendar month following the calendar month in which the hospital inpatient stay began.

b. Emergency situations. Benefits under the PFTH may be continued in authentic emergency situations, such as serious illness or death in the immediate family, but in no case longer than 7 days including travel time.

c. Therapeutic absences. When a handicapped dependent leaves an institution for a therapeutic absence, benefits under the PFTH may be continued for a period not to exceed 72 hours including travel time.

d. Holiday or school vacation. When a handicapped dependent leaves an institution for a recognized holiday or school vacation during the school term, benefits under the PFTH are limited to no more than 7 days each, including travel time, except that one such absence of up to 15 days, including travel time, is authorized each year. Payments for holiday and vacation absences are authorized only when all paying patients in the facility are charged for the absence.

e. Recording of absences. All absences must be noted on the claim form and a detailed statement attached to the claim form explaining the duration and reason for the absence. Failure to do so will result in termination of benefits.

C. CRITERIA FOR QUALIFYING FOR PFTH BENEFITS

1. General requirements. To be considered for benefits, the applicant must be determined medically to be moderately or severely mentally retarded or seriously physically handicapped to the following extent:

a. Duration of handicap. The condition is expected to result in death, or has lasted, or is, with reasonable certainty, expected to last for a minimum of 12 months; and

b. Extent of handicap. The disability caused by the handicap is of such severity as to preclude the handicapped applicant from engaging substantially in basic productive activities of daily living expected of unimpaired persons of the same age group.

2. Management plan. The services and supplies provided the applicant under the PFTH must be appropriate to the applicant's disability and, to the greatest extent possible, should benefit the applicant through the treatment of the disabling condition or by enhancing the applicant's ability to cope with or overcome the disability. The primary goal of the PFTH is to maximize the potential of the handicapped person to achieve as normal a life style as possible and to maintain the handicapped person in or to return the handicapped person to the home, public school, and community environment, whenever possible.

3. Purchase limitations. Such services and supplies as may be authorized for purchase under the PFTH are limited appropriately to functional and utilitarian services and supplies. Utility and economy will be given primary consideration in approval of equipment.

EXAMPLE: When basic mobility is required, a manual wheelchair will be authorized, unless the physical disability is such that only an electric wheelchair is suitable.

4. Application approval

a. Authority for approval. The Director, OCHAMPUS, is vested with the final authority on all applications for coverage under the PFTH. This includes the determination as to the severity of the handicap and the appropriateness of the supplies or services to the handicapping condition for which coverage is requested. The Director, OCHAMPUS, or a designee, shall request such information as is deemed necessary to make these determinations before issuing approvals or denials. Failure to supply such information will result in deferral or denial of the application for coverage.

b. Deferral or denial of application. In those situations where a deferred or denied application for coverage under the PFTH subsequently is approved, such subsequent approval may be applied retroactively to the date coverage would have been effective had adequate information been provided.

D. MENTAL RETARDATION

1. Definition. Mental retardation refers to subnormal general intellectual functioning and is associated with impairment of either learning and social adjustment or maturation, or both. The diagnostic classification of moderate and severe mental retardation relates to intelligence quotient (IQ) as follows:

- a. Moderate. Moderate mental retardation equates to IQ 36-51.
- b. Severe. Severe mental retardation equates to IQ 35 and under.

NOTE: It is recognized that IQ should not be the only criterion used in making a diagnosis of mental retardation or in evaluating its severity. It should serve only to help in making a clinical judgment of the patient's adaptive behavioral capacity. This judgment also should be based on an evaluation of the patient's developmental history and present functioning, including academic and vocational achievement, motor skills, and social and emotional maturity.

2. Acceptable tests to measure intelligence. The Wechsler Preschool and Primary Scale of Intelligence (WPPSI), the Wechsler Intelligence Scale for Children (WISC) or Wechsler Adult Intelligence Scale (WAIS) are the CHAMPUS instruments of choice to determine IQ; however, a Stanford-Binet will be accepted. A person who cannot be tested by an age-appropriate instrument listed above can be tested by another test, provided that an acceptable explanation of why one of the listed tests could not be used is furnished to OCHAMPUS, along with a detailed explanation of "scoring" the test, for the purpose of statistical comparison with one of the above tests. IQ tests must be interpreted by a qualified psychologist certified by the state where the test is administered. In states where certification is not required, the psychologist must have at least a master's degree in psychology. In states that certify "psychometrists" to administer and interpret IQ tests, that certification will suffice.

E. SERIOUS PHYSICAL HANDICAP

1. Definition. Serious physical handicap means a medical condition of the body that meets the following criteria:

- a. Duration of handicap. The condition is expected to result in death, or which has lasted, or with reasonable certainty is expected to last, for a minimum period of 12 months; and
- b. Extent of handicap. The condition is of such severity as to preclude the handicapped person from engaging substantially in basic productive activities of daily living expected of unimpaired persons of the same age group. For example:

(1) Persons older than high school age generally must be unable to engage in gainful pursuits because of the handicap.

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(2) Persons of up to and through high school age must be unable to be provided an education through the public school system because of the handicap.

2. Examples of conditions that may cause serious physical handicaps.

Examples include, but are not limited to, the following listed categories:

a. Visual impairment, age 7 and over. A vision impairment will be considered serious in persons 7 years of age and older if the handicapped person requires assistance to support the activities of daily living and if the following apply:

(1) The remaining vision in the better eye after best correction is 20/200 or less; or

(2) The contraction of visual fields is to 10 degrees or less from the point of fixation; or

(3) The widest diameter subtends an angle no greater than 20 degrees; or

(4) The visual efficiency of the better eye after best correction is 20 percent or less; or

(5) Other conditions impairing visual function such as complete homonymous hemianopsia, or total bilateral ophthalmoplegia.

b. Visual impairment, under age 7. A visual impairment in children under 7 years of age will be considered serious (even if correctable with lenses) when the visual impairment is manifested by 20/60 vision or less.

c. Hearing impairment, testable patients. A hearing impairment is a serious physical handicap when, unaided by amplification, it is manifested by the following:

(1) A 45 decibel hearing threshold level (HL) or poorer in either ear tested at 1,000; 2,000; or 3,000 Hertz (Hz) frequencies; or by

(2) A 30 decibel HL or poorer in each ear tested at 1,000; 2,000 or 3,000 Hz frequencies; or by

(3) Speech discrimination of 60 percent or poorer with either ear.

d. Hearing impairment, nontestable patients. When pure tone audiometry or speech discrimination testing is not available or not reliable because of the patient's age or condition, the attending physician must submit documentation that demonstrates the patient is unable to engage in basic productive activities of daily living expected of unimpaired persons of the same age group. An example of acceptable documentation would be electrophysiological tests of hearing such as auditory evoked potential testing or a behavioral assessment that shows that, without special help, an infant with a hearing impairment will not develop normal language. Each case will be reviewed on its own merits.

e. Epilepsy, major. Major motor seizures (grand mal or psychomotor) substantiated by an electroencephalogram (EEG), occurring more frequently than once a month despite prescribed treatment. With:

(1) Diurnal episodes (loss of consciousness) and convulsive seizures;
or

(2) Nocturnal episodes that show residuals interfering with activity during the day; and

(3) Both or either of the above that have reached the point when the handicapped person requires assistance to support the activities of daily living.

f. Epilepsy, minor. Minor motor seizures (petit mal or psychomotor) substantiated by an EEG, occurring more frequently than once weekly despite prescribed treatment. With:

(1) Alteration of awareness or loss of consciousness; and

(2) Transient postictal manifestations of unconventional or antisocial behavior; and

(3) Both of the above that have reached the point when the handicapped person requires assistance to support the activities of daily living.

g. Paralysis agitans (Parkinson's disease). With: tremor, rigidity, and significant impairment of mobility (for example, festination) that has reached the point when the handicapped person requires assistance to support the activities of daily living.

h. Cerebral palsy. With:

(1) IQ of 83 or less; or

(2) Abnormal behavior patterns, such as destructiveness, or emotional instability; or

(3) Significant interference in communication due to speech, hearing, or visual defect; or

(4) Significant motor deficit in two extremities; and

(5) Any of the above having reached a point when the handicapped person requires assistance to support the activities of daily living.

i. Multiple sclerosis. With:

(1) Significant motor deficits in two extremities; and

(2) Ataxia substantiated by appropriate cerebellar signs or proprioceptive loss; and

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(3) Both of the above that have reached the point when the handicapped person requires assistance to support the activities of daily living.

j. Muscular dystrophy. With

(1) Significant motor impairment and restricted mobility; and

(2) Flexion deformities of both lower extremities; or

(3) Significant weakness or paralysis of muscles of the shoulder girdle or of the neck, with abduction of both arms at the shoulder restricted to less than 90 degrees; and

(4) The conditions having reached the point when the handicapped person requires assistance to support the activities of daily living.

k. Degenerative neurological diseases. Other degenerative neurological diseases (such as Huntington's chorea, Friedrich's ataxia, or spinocerebellar degeneration) that have reached the point when the handicapped person requires assistance to support the activities of daily living.

l. Musculoskeletal system. Serious impairments of the musculoskeletal system that have reached the point when the handicapped person requires assistance to support the activities of daily living.

m. Respiratory system. Serious impairments of the respiratory system that have reached the point when the handicapped person requires assistance to support the activities of daily living.

n. Trauma. Serious impairments resulting from trauma that are at a level that requires assistance to support the activities of daily living.

o. Diabetes mellitus. Severe physical limitations resulting from diabetes mellitus occurring in children (that is, under 18 years of age) that have reached the point when the handicapped person requires assistance to support the activities of daily living.

p. Multiple conditions. Two or more conditions involving separate body systems, neither condition in itself seriously handicapping, but which combined are of such severity as to limit activities in a seriously handicapping manner and have resulted in the handicapped person requiring assistance to support the activities of daily living. Each such multiple condition case will be reviewed on its own merits.

F. PROCEDURES FOR OBTAINING BENEFITS

Active duty members seeking benefits under the PFTH for a dependent spouse or child must secure authorization from OCHAMPUS for such benefits in advance. Payment will not be made for any services or supplies under the PFTH received or obtained before approval of the application by the Director, OCHAMPUS, or a designee. If a beneficiary fails to obtain preauthorization before receiving the services, the Director, OCHAMPUS, or a designee, may extend CHAMPUS benefits if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization.

1. Completed application. Application is made by completing a CHAMPUS Form 190a, "Request for Health Benefits Under the Program for the Handicapped" (as may be amended), and mailing it to the Director, OCHAMPUS, Aurora, Colorado 80045-6900.

2. Additional required information. The applicant also shall submit, along with the required CHAMPUS Form 190a, the following:

a. Statement of dependent's condition. A medical statement of the dependent's condition, giving a specific diagnosis, using the most current ICD-CM, history of mental retardation or physical handicap, present condition, prognosis, and a proposed, detailed management plan for the handicapping condition, including estimated charges or costs. This statement must be signed by the supervising physician. The medical report may be submitted directly by the physician if so desired.

b. Use of other than public facilities. Within the United States, if the management plan proposes to use other than public facilities, a statement is required from a cognizant public official certifying to the fact that public facilities are or are not available or are or are not adequate to meet the needs of the handicapped dependent, and that public funds are or are not made available for support of the needs of the handicapped dependent in alternative facilities deemed adequate.

NOTE: Inasmuch as there is great diversity in the types of public programs and institutions offering services to the handicapped, it is impossible to list in detail the cognizant public officials in each state, county, or local community. As a general rule, the cognizant public official is associated with a public program and has broad knowledge of and authority for providing, the services related to the types of handicap for which CHAMPUS benefits are being requested. For example, in the case of a mentally retarded school-age child who needs to be placed in a special class for the educable handicapped, the cognizant public official could be the Director of Special Education for the local school district rather than the principal of the nearest school. In some states where special educational programs are managed at the state level, the cognizant public official may have to be the State Director of Special Education. In still other cases when some kind of vocational rehabilitation is required, the cognizant public official may be an official in the State Department of Vocational Rehabilitation; while in another state all vocational rehabilitation programs may be controlled by the Department of Human Resources or the Department of Social Services. It is the sponsor's responsibility to determine the appropriate cognizant public official.

c. Information on available programs. OCHAMPUS will assist a sponsor to obtain information from those agencies that are possible sources of assistance for the specific condition.

d. Application review procedure. A review of PFTH applications shall be done by the Director, OCHAMPUS, or a designee, who shall:

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(1) Determine if the dependent's degree of mental retardation or physical disability (as documented by a physician) is such as to qualify for benefits;

(2) Evaluate the proposed management plan to determine if it is appropriate to the handicapping condition and if the charge or cost is reasonable; or if the services to be provided can be obtained more effectively and economically in another CHAMPUS-approved facility providing the same services; and

(3) Evaluate the cognizant public official's statement if the management plan proposes the use of private facilities. If in the opinion of the Director, OCHAMPUS, or a designee, the statement of the cognizant public official is inadequate or inappropriate, additional information will be required and the sponsor will be required to contact the agency or official determined to be most cognizant of PFTH in the sponsor's community and obtain a statement as to availability or nonavailability of appropriate public facilities.

NOTE: Because of both the wide variety of handicapping conditions and the large number of public institutions and agencies that operate independently of each other, the Director, OCHAMPUS, or a designee, will establish contact with these institutions and agencies and offer information and assistance on CHAMPUS beneficiaries so that they can obtain access to those public programs to which they have a legal entitlement. This will include information on such matters as the Interstate Compact in which many states participate, state laws regarding the right to education, services under the Rehabilitation Act (reference (aa)), and similar programs. Approval for PFTH benefits will be issued only when it has been determined to the satisfaction of the Director, OCHAMPUS, or a designee, that the required services are not available from public sources and that the proposed plan of management will be beneficial to the handicapped person.

e. Application approval, limitations. The application approval will be specific as to the approved facility, management plan, or services and supplies being authorized under the PFTH as well as the specific period of time for which authorization is being made. The application approval also may list other requirements (such as a specific reevaluation requirement in 6 months).

NOTE: The approved application is valid only for 90 days. If admission to the approved facility is not accomplished or the management plan is not commenced within 90 days of the date the application is approved, a new application must be submitted for evaluation.

f. Periodic review and reevaluation. A periodic review and reevaluation of the status of dependents who have been approved for coverage under the PFTH will be conducted by the Director, OCHAMPUS, or a designee, under the following circumstances:

(1) At least annually. The supervising physician's report, a completed CHAMPUS Form 141, "Diagnostic Evaluation, Program for the Handicapped," a new, updated management plan, and a new cognizant public official's statement will be submitted reflecting any changes that may have occurred in the 12-month period.

NOTE: The Director, OCHAMPUS, or a designee, may require that any specific case be reviewed more often than annually.

(2) Change of institution. When a dependent handicapped beneficiary is removed from an institution that was approved under the PFTH, placement in a new institution requires a new application.

(3) Sponsor reassignment. A sponsor who is reassigned to another location within the United States will be required to determine within 60 days from the date of reporting to a new duty assignment if public facilities appropriate to the needs of the handicapped dependent are available. If they are not, it will be necessary to substantiate this fact with a new cognizant public official's statement. Failure to take such action will result in termination of coverage under the PFTH on the 61st day following the date the sponsor reported to the new duty assignment.

NOTE: If it is determined that public facilities are available at the new location, the Director, OCHAMPUS, or a designee, may determine that the handicapped beneficiary may continue to receive benefits for inpatient care at the former location under the PFTH until the end of the current school year.

G. USE OF PUBLIC FACILITIES

To qualify for benefits under the PFTH, public facilities or state funds must be used to the greatest extent they are available or adequate.

1. Statement of school official or other cognizant public official. For dependents for whom special educational benefits are requested, the sponsor must submit a statement from the superintendent of the local public school district, or designee, that the public school district is aware in detail of the dependent's tested educational handicaps and that an adequate education opportunity is or is not available for the dependent, either in the public schools or through public resources. A statement must be made by certificate whether or not applicable law requires public funds to help defray the cost of private schooling if public schooling is not available or adequate, and if the law requires such funding. If there is a waiting list for adequate public care, the anticipated length of wait must be stated. A new statement from the superintendent of the local public school district, or a designee, will be required at the beginning of each school year or more frequently, as determined by the Director, OCHAMPUS, or a designee.

2. Determination that public facility is adequate. A certified statement by a cognizant public official that a public facility or service is or is not available and is or is not adequate to meet the needs of the handicapped spouse or child is prima facie evidence of the facts stated. The Director,

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OCHAMPUS, or a designee, has final authority in determining whether a facility is available and adequate. CHAMPUS benefits will not be extended when the beneficiary or sponsor elects not to use the public facilities that have been determined to be available and adequate.

3. State contracts with private facilities. As an exception, when a state government (but not a county or municipal government) contracts for institutional care in private facilities, payment to the state is authorized since the care provided in such facilities or homes is considered to be state institutional care. In such a case, the following four requirements must be met and appropriate documentation submitted:

a. Determination of state responsibility. A determination must be made by the state that it has a responsibility for providing care for the dependent's handicapping condition.

b. Determination that public facility placement cannot be made. The state or other local jurisdiction must determine that the dependent cannot be placed in a public facility and no state funds are available for such care.

c. State must make placement. The state must make the placement, or determine that it is responsible for a dependent already placed.

d. Acceptable billing and financial procedure. The state must be billed for the services provided by the private facility. The state may not simply act as an "intermediary" or a conduit for billing and payment purposes; and CHAMPUS cannot be billed by the state for a greater amount than that billed to other non-CHAMPUS patients in like circumstances.

H. COVERED SERVICES AND SUPPLIES

1. General. As a general rule, the services and supplies covered under the PFTH are those that contribute directly to the habilitation or rehabilitation of the handicapped dependent. This may include institutional care when the severity of the disability requires protective custody in an institutional setting. Active medical or surgical treatment of an acute illness may be considered under the Basic Program when such treatment is not included as a part of the management plan or a routine part of the institutional services approved under the PFTH. Notwithstanding, all services, supplies, and equipment required by and directly related to the handicapping conditions, including those services and supplies approved under the management plan, shall be considered for benefits only under the PFTH, whether or not under other circumstances Basic Program benefits could apply. The only exception to this requirement is a serious, acute exacerbation of the handicapping condition requiring an inpatient hospital stay. In such a case, Basic Program benefits are applicable for the required period of hospitalization.

EXAMPLES:

a. A mentally retarded child in an institution for the retarded becomes ill with appendicitis and is admitted to a general hospital for surgery. The charges related to the inpatient episode in a general hospital for the acute appendicitis are considered under the Basic Program.

b. Another dependent with a neurological disability, such as Parkinson's disease, is placed, under the PFTH, in an institution for patients similarly afflicted. The institutional charges are all inclusive and all residents receive services, such as routine medications, diet supplements, and periodic medical examinations, and those services and supplies are part of the total management plan. This situation would be cost-shared under the PFTH and benefits would not be available under the Basic Program.

c. In the third situation, a dependent who is placed in an institution under the PFTH because of Huntington's chorea, experiences an acute episodic period that warrants admission to a hospital for medical treatment of the acute phase and which was not included as a part of the approved management plan. This inpatient hospital care would be considered for benefits under the Basic Program.

2. Extent of covered services and supplies. Subject to such other definitions, conditions, limitations, and exclusions enumerated in this and other chapters of this Regulation, the following services and supplies (including durable equipment) are covered under the PFTH:

a. Diagnostic evaluation. Diagnostic evaluation on either an inpatient or outpatient basis by a physician. This includes hospitalization or institutionalization solely for the purpose of conducting diagnostic studies performed by or under the supervision of a physician if such an inpatient setting is medically necessary to perform the diagnostic evaluation. Diagnostic evaluations do not require prior approval, but are payable only in those cases resulting in approval of the handicapped beneficiary under the PFTH. If the diagnostic evaluation is done on an inpatient basis, any benefits for the inpatient stay related to such evaluation will not exceed 5 days of an inpatient stay.

b. Durable equipment. The purchase of durable equipment may be authorized when certified by a physician as necessary in the treatment, habilitation, or rehabilitation of a handicapped beneficiary. Except under extremely unusual situations (which would require individual review and consideration), durable equipment required by an institutionalized handicapped beneficiary must be provided by the institution as a part of the management plan and included in the monthly institutional charges.

(1) To qualify as durable equipment under the PFTH, the item will be evaluated against the following criteria:

(a) It clearly must be related to and necessary for the habilitation, treatment, or training of beneficiaries with the given handicap.

(b) It must improve the function of a malformed body member or retard further deterioration of the handicapped beneficiary's physical condition.

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(c) It cannot be useful to anyone in the absence of a physical or mental disability.

(d) It must be used primarily and customarily to serve a medical or habilitative purpose rather than primarily for transportation, comfort, or convenience.

NOTE: A wheelchair (or CHAMPUS-approved alternative) is not considered transportation in the sense of subparagraph H.2.b.(1)(d), above. It is qualified as durable equipment under subparagraph H.2.b.(1)(b), above, because by providing basic mobility, it retards further deterioration of the patient's physical condition. Mobility beyond that basic mobility provided by a wheelchair (or a CHAMPUS-approved alternative) is considered to be primarily transportation.

(e) It cannot be beyond the appropriate level of performance and quality required under the circumstances (that is, nonluxury and nondeluxe). However, this subparagraph is not intended to preclude special fitting of equipment to accommodate a particular disability (such as fitting a wheelchair for a one-armed handicapped person).

(f) It is not available for loan from a local Uniformed Services medical treatment facility.

(g) Only one similar item of durable equipment will be purchased during any one period of time, and benefits include repair of durable equipment purchased under the PFTH and its later replacement if it is determined that the previous item is no longer usable.

(h) There must be written preauthorization by OCHAMPUS before the date of purchase of durable equipment. Such authorization is specific as to the item of durable equipment being approved. Further, such authorization is only valid for 90 days from the date issued. If the item of durable equipment is not purchased within the time limit, a new preauthorization is required. Purchases of durable equipment may not be approved retroactively.

(i) Benefits also may be extended for the allowable charges for repair and replacement parts (such as batteries), including adjustment of durable equipment purchased under the PFTH. Such repair or part replacement or adjustment does not require preauthorization, unless the charge is \$50 or more. In the case of an emergency, a charge above that amount may be considered without preauthorization, subject to special review.

(2) Cost-sharing of durable equipment purchases. Durable equipment normally will be cost-shared in the month that the purchase is made. However, when the durable equipment is a high charge or cost item, the sponsor or the beneficiary has the option of prorating the purchase price in equal monthly installments over a period not to exceed 6 months, and beginning with the month of purchase. In no case shall payments be made by CHAMPUS beyond termination of eligibility as a CHAMPUS beneficiary. No other payment option is available.

c. Prescription drugs and medicines. Prescription drugs and medicines, and insulin for a known diabetic. Drugs and medicines are limited to those approved for general use by humans (other than testing) by the U.S. Food and Drug Administration.

d. Outpatient treatment. Such outpatient treatment as may be appropriate to the treatment and habilitation of the handicapped person related to the handicapping condition is coverable. Such services include, but are not limited to, physical therapy, occupational therapy, vocational training, speech therapy, and special educational services.

e. Home treatment. Certain services authorized by this section may be provided to the handicapped person in the home if that setting is considered the most reasonable and appropriate. Such services include, but are not limited to, physical therapy, occupational therapy, vocational training, speech therapy, and special educational services.

f. Institutional care (inpatient). Institutional care within the PFTH is primarily long-term residential (inpatient) care for the handicapped person in private nonprofit, public, or state institutions and facilities. Such institutions include, but are not limited to, schools for the deaf and blind and institutions for physically or mentally handicapped persons.

g. Special optical devices. Certain special optical devices necessary to ameliorate the handicapping condition are covered, but are limited to the following:

(1) Contact lenses necessary to correct a visual handicap that qualifies under paragraph E.2.a. of this chapter.

(2) Subnormal visual corrective devices such as telescopic and isoiconic lenses.

(3) Optical aids such as hand-held optical devices for reading.

h. Prosthetic devices and orthopedic appliances. Prosthetic devices and orthopedic appliances that are needed to correct or overcome a physical disability are covered. This includes artificial limbs and orthopedic braces.

i. Professional services. The services of a wide variety of both medical and educational professionals are covered. Their services may be provided either on an inpatient or an outpatient basis subject to the following criteria:

(1) Services of professional personnel include, but are not limited to, the services of physicians, dentists, optometrists, speech pathologists, audiologists, physical therapists, occupational therapists, and nurses. Such professional personnel must be licensed within the jurisdiction in which the services are provided and must otherwise be in compliance with applicable federal and state laws regarding the practice of their specialty. Where there is no license requirement, they must be eligible for membership in the state or national association setting the standards for their respective group.

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(2) Services of teachers of the handicapped who meet the standards of the school system in the jurisdiction in which located and who provide special education such as, but not limited to, remedial reading, speech training, or special classes for seriously physically handicapped or moderately or severely mentally retarded children.

(3) Services of vocational instructors who teach physically handicapped or mentally retarded persons a trade or occupation, for example, teaching a blind person to be a mechanic or typist. These instructors must meet the standards of the school system where the training is being conducted.

(4) The Director, OCHAMPUS, or a designee, is the final authority whether a professional (either a person or a class) is approved as an authorized professional provider under the PFTH.

j. Related therapy. Therapy, such as family counseling, for parents of a handicapped child is authorized when needed as an integral part of the treatment for the child, as determined by the Director, OCHAMPUS, or a designee, and approved as a part of the management plan.

k. Special tutoring. Tutoring by qualified tutors provided on an outpatient basis or in the patient's home to dependents who are either physically handicapped or moderately or severely mentally retarded is an authorized benefit. Tutors must meet qualifications outlined in subparagraphs H.2.i.(1), (2), (3), and (4), above. Private tutoring to supplement a public education or special education enhancement programs, or a training program for a child temporarily disabled due to acute illness or injury, is not covered under the PFTH.

l. Surgery and medical care. When necessary to treat or correct a handicapping condition as defined in this chapter by the terms "mental retardation" (moderate or severe) or "serious physical handicap," surgery and medical care may be authorized either on an inpatient or outpatient basis. When appropriate and approved as a part of the management plan, this may include authorized adjunctive dental care.

m. Training and special education

(1) Education or training needed to alleviate, overcome, or adjust to a serious physical handicap or moderate or severe mental retardation is an authorized benefit, provided it is included as a part of the approved management plan. This includes, but is not limited to, remedial reading, speech training, use of artificial aids, and education provided physically handicapped and mentally retarded persons on either an inpatient or outpatient basis.

(2) Training and special education also includes special vocational training or education wherein a physically handicapped or mentally retarded person is taught a trade or occupation to aid in overcoming or adjusting to his or her condition (such as teaching a blind person to be a mechanic or typist), but in no event beyond the high school level.

n. Transportation

(1) Transportation is authorized for medically eligible handicapped dependents by government, commercial, public, or private means to and from approved facilities in which the dependent is to receive or has received institutional care for which benefits have been approved under the PFTH. Transportation must be necessary and justified by the attending physician.

(2) Transportation benefits may be requested in conjunction with an application for other benefits under the PFTH, or a request for approval of transportation benefits may be submitted separately.

(3) If other than local public transportation or transportation by privately owned vehicles is to be used, a request for approval must be supported with evidence that a less expensive means of transportation is not available, or that the means to be used is medically necessary.

(4) With respect to local transportation, if more than two round trips daily are necessary, supporting justification must be submitted. In every instance when government transportation is available, it must be used.

(5) When distant transportation is medically necessary, government transportation, when available, shall be used. Under very unusual circumstances, if determined to be medically necessary and also certified by the attending physician, transportation for a medical attendant may be approved.

o. Transportation restrictions

(1) Transportation benefits are subject to the \$1,000 per month limitation on government cost under the PFTH and must be applied during the month the transportation actually occurs. The cost may not be prorated over a period of months. Any transportation cost shall be added to any other cost of care under the PFTH for that month.

(2) Reimbursement for travel costs will be made on the basis of actual transportation costs when transportation is by privately owned vehicle or the ticket costs in the case of other kinds of travel, plus other reasonable transportation costs, such as airport limousine, in connection with medically necessary air travel. Receipted bills must be obtained for any transportation costs not covered by a ticket. The cost of meals, motels, and tips that may be related to transportation is not an authorized benefit.

(3) When commercial transportation is used, the least expensive form only is authorized, such as coach or tourist class rather than first-class accommodations. Travel outside the United States is not authorized.

(4) Transportation is payable only to or from a public or private nonprofit facility. Transportation costs to or from a proprietary facility will not be paid.

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(5) Carpooling will be required whenever possible when two or more handicapped dependents are seeking reimbursement of travel costs by private vehicle to and from the same location. Only the owner or operator of the vehicle used in the carpool may be reimbursed. Reimbursement is limited to actual transportation costs or \$0.155 per mile, whichever is lower.

I. UTILIZATION REVIEW AND QUALITY ASSURANCE

It is the intent of this Regulation that before any benefits may be extended, any services and supplies furnished by any provider shall be subject to utilization review and quality assurance standards, norms, and criteria issued by the Director, OCHAMPUS, or a designee.

J. GENERAL LIMITATIONS

All services and treatment received under the PFTH must be in connection with the handicapping condition. Medical or surgical services required, but not in connection with the handicapping condition, can be considered for benefits under the Basic Program. In such a situation, the active duty service member is responsible for cost-sharing under both programs. The following services are not covered under the PFTH:

1. Academic education. Specialized academic education for those with educational or learning disabilities, normally provided in a public school system or institution of higher learning, is not covered under the PFTH. These learning disabilities include dyslexia, perceptual handicaps, hyperkinetic behavior syndrome, neurological dysfunction, reading disability, and minimal brain dysfunction. (This does not exclude learning disabilities that are derived from or related to moderate or severe mental retardation or a serious physical handicap.)

2. Alterations. Alterations to living space and permanent fixtures attached thereto, even when necessary to accommodate installation of covered durable equipment or to facilitate entrance or exit, are not authorized for payment under the PFTH.

3. Homemaker, sitter or companion services. Homemaker, sitter, or companion services are not covered.

4. Dental care. Dental care, except as adjunctive dental care required in the treatment of a handicapping condition, is not authorized. Orthodontic treatment is not authorized under any circumstance.

5. Nonapproved drugs and medications. Drugs and medications not approved for general use by humans by the U.S. Food and Drug Administration, whether or not legally available outside the United States. However, if a drug or medicine is listed in the U.S. Pharmacopeia or the National Formulary and requires a prescription, it is not excluded by this provision even if it is under investigation by the U.S. Food and Drug Administration as to its effectiveness.

NOTE: In areas outside the United States, standards similar to those of the U.S. Food and Drug Administration is the CHAMPUS objective.

6. Outside the United States. Facilities outside the United States are not eligible as approved facilities under the PFTH, regardless of whether otherwise qualified. In addition, any excursions outside the United States are not covered even though part of a program offered by an approved facility is in the United States.

K. AUTHORITY TO DETERMINE ELIGIBILITY UNDER PFTH

The Director, OCHAMPUS, or a designee, is authorized to review a Basic Program case and make a determination that the particular beneficiary meets the definition of a moderately or severely retarded or seriously physically handicapped dependent as set forth in sections D. and E. of this chapter, whether or not an application for benefits under the PFTH has been submitted by the sponsor. In such event, the Director, OCHAMPUS, or designee, will notify the sponsor that benefits for services or supplies related to the handicapping condition or conditions are no longer available under the Basic Program (except under those circumstances specifically set forth in this chapter), and further, that the Basic Program case will be transferred to the PFTH as of the 1st day of the 2nd month following the date of such notice.

L. IMPLEMENTING INSTRUCTIONS

The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, guidelines, standards, and criteria as may be necessary to implement the intent of this chapter.

CHAPTER 6
AUTHORIZED PROVIDERS

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CHAPTER 6
AUTHORIZED PROVIDERS

A. GENERAL

This chapter sets forth general policies and procedures that are the basis for the CHAMPUS cost-sharing of medical services and supplies provided by institutions, individuals, or other types of providers. Providers seeking payment from the Federal Government through programs such as CHAMPUS have a duty to familiarize themselves with, and comply with, the program requirements.

1. Listing of provider does not guarantee payment of benefits. The fact that a type of provider is listed in this chapter is not to be construed to mean that CHAMPUS will automatically pay a claim for services or supplies provided by such a provider. The provider who actually furnishes the service(s) must, in fact, meet all licensing and other requirements established by this Regulation to be an authorized provider; the provider must not be the subject of sanction under Chapter 9; and, cost-sharing of the services must not otherwise be prohibited by this Regulation. In addition, the patient must in fact be an eligible beneficiary and the services or supplies billed must be authorized and medically necessary, regardless of the standing of the provider.

2. Outside the United States or emergency situations within the United States. Outside the United States or within the United States and Puerto Rico in emergency situations, the Director, OCHAMPUS, or a designee, after review of the facts, may provide payment to or on behalf of a beneficiary who receives otherwise covered services or supplies from a provider of service that does not meet the standards described in this Regulation.

NOTE: Only the Secretary of Defense, the Secretary of Health and Human Services, or the Secretary of Transportation, or their designees, may authorize (in emergency situations) payment to civilian facilities in the United States that are not in compliance with title VI of the Civil Rights Act of 1964 (reference (z)). For the purpose of the Civil Rights Act only, the United States includes the 50 states, the District of Columbia, Puerto Rico, Virgin Islands, American Samoa, Guam, Wake Island, Canal Zone, and the territories and possessions of the United States.

3. Dual compensation/conflict of interest. Title 5, United States Code, section 5536 (reference (bb)) prohibits medical personnel who are active duty Uniformed Service members or civilian employees of the Government from receiving additional Government compensation above their normal pay and allowances for medical care furnished. In addition, Uniformed Service members and civilian employees of the Government are generally prohibited by law and agency regulations and policies from participating in apparent or actual conflict of interest situations in which a potential for personal gain

exists or in which there is an appearance of impropriety or incompatibility with the performance of their official duties or responsibilities. The Departments of Defense, Health and Human Services, and Transportation have a responsibility, when disbursing appropriated funds in the payment of CHAMPUS benefits, to ensure that the laws and regulations are not violated. Therefore, active duty Uniformed Service members (including a reserve member while on active duty) and civilian employees of the United States Government shall not be authorized to be CHAMPUS providers. While individual employees of the Government may be able to demonstrate that the furnishing of care to CHAMPUS beneficiaries may not be incompatible with their official duties and responsibilities, the processing of millions of CHAMPUS claims each year does not enable Program administrators to efficiently review the status of the provider on each claim to ensure that no conflict of interest or dual compensation situation exists. The problem is further complicated given the numerous interagency agreements (for example, resource sharing arrangements between the Department of Defense and the Veterans Administration in the provision of health care) and other unique arrangements which exist at individual treatment facilities around the country. While an individual provider may be prevented from being an authorized CHAMPUS provider even though no conflict of interest or dual compensation situation exists, it is essential for CHAMPUS to have an easily administered, uniform rule which will ensure compliance with the existing laws and regulations. Therefore, a provider who is an active duty Uniformed Service member or civilian employee of the Government shall not be an authorized CHAMPUS provider. In addition, a provider shall certify on each CHAMPUS claim that he/she is not an active duty Uniformed Service member or civilian employee of the Government.

4. For-profit institutions excluded under the Program for the Handicapped (PFTH). 10 U.S.C. 1079(d)(4) (reference (a)) precludes payment of benefits under the PFTH for otherwise covered services and supplies provided by a for-profit institution (refer to Chapter 5 of this Regulation).

5. Utilization review and quality assurance. Providers approved as authorized CHAMPUS providers have certain obligations to provide services and supplies under CHAMPUS which are (i) furnished at the appropriate level and only when and to the extent medically necessary under the criteria of this Regulation; (ii) of a quality that meets professionally recognized standards of health care; and, (iii) supported by adequate medical documentation as may be reasonably required under this Regulation by the Director, OCHAMPUS, or a designee, to evidence the medical necessity and quality of services furnished, as well as the appropriateness of the level of care. Therefore, the authorization of CHAMPUS benefits is contingent upon the services and supplies furnished by any provider being subject to pre-payment or post-payment utilization and quality assurance review under professionally recognized standards, norms, and criteria, as well as any standards or criteria issued by the Director, OCHAMPUS, or a designee, pursuant to this Regulation. (Refer to Chapters 4, 5, and 7 of this Regulation.)

6. Provider required. In order to be considered for benefits, all services and supplies shall be rendered by, prescribed by, or furnished at the direction of, or on the order of a CHAMPUS-authorized provider practicing within the scope of his or her license.

7. Participating provider. Under CHAMPUS, authorized professional providers and institutional providers other than hospitals have the option of participating on a claim-by-claim basis. Participation is required for inpatient claims only for hospitals which are Medicare-participating providers. Hospitals which are not Medicare-participating providers but which are subject to the CHAMPUS DRG-based payment system in subsection A.1. of Chapter 14 or the CHAMPUS mental health per diem payment system in subsection A.2. of Chapter 14 must sign agreements to participate on all CHAMPUS inpatient claims in order to be authorized providers under CHAMPUS. All other hospitals may elect to participate on a claim-by-claim basis. Participating providers must indicate participation by signing the appropriate space on the applicable CHAMPUS claim form and submitting it to the appropriate CHAMPUS fiscal intermediary on behalf of the beneficiary. In the case of an institution or medical supplier, the claim must be signed by an official having such authority. This certifies that the provider has agreed to accept the CHAMPUS-determined allowable charge or cost as payment in full for the medical services and supplies listed on the specific claim form; and has agreed to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing and deductible amounts paid by, or on behalf of, the beneficiary as full payment for the covered medical services and supplies.

8. Limitation to authorized institutional provider designation. Authorized institutional provider status granted to a specific institutional provider applicant does not extend to any institution-affiliated provider, as defined in Chapter 2 of this Regulation, of that specific applicant.

9. Authorized provider. A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized in this chapter to provide benefits under CHAMPUS. In addition, to be an authorized CHAMPUS provider, any hospital which is a CHAMPUS participating provider under Section A.7. of this chapter, shall be a participating provider for all care, services, or supplies furnished to an active duty member of the uniformed services for which the active duty member is entitled under title 10, United States Code, section 1074(c). As a participating provider for active duty members, the CHAMPUS authorized hospital shall provide such care, services, and supplies in accordance with the payment rules of Chapter 16. The failure of any CHAMPUS participating hospital to be a participating provider for any active duty member subjects the hospital to termination of the hospital's status as a CHAMPUS authorized provider for failure to meet the qualifications established by this chapter.

B. INSTITUTIONAL PROVIDERS

1. General. Institutional providers are those providers who bill for services in the name of an organizational entity (such as hospital and skilled nursing

facility), rather than in the name of a person. The term "institutional provider" does not include professional corporations or associations qualifying as a domestic corporation under section 301.7701-5 of the Internal Revenue Service Regulations (reference (cc)), nor does it include other corporations that provide principally professional services. Institutional providers may provide medical services and supplies on either an inpatient or outpatient basis.

a. Preauthorization. The Director, OCHAMPUS, reserves the right to require preauthorization for admission to inpatient facilities. Refer to Chapter 4, subsection A.11., for information on preauthorization.

b. Billing practices.

(1) Each institutional billing, including those institutions subject to the CHAMPUS DRG-based reimbursement method or a CHAMPUS-determined all-inclusive rate reimbursement method, must be itemized fully and sufficiently descriptive for the CHAMPUS to make a determination of benefits.

(2) Institutional claims subject to the CHAMPUS DRG-based reimbursement method or a CHAMPUS-determined all-inclusive rate reimbursement method, may be submitted only after the beneficiary has been discharged or transferred from the institutional provider's facility or program.

(3) Institutional claims for Residential Treatment Centers and all other institutional providers, except those listed in subparagraph (2) above, should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days.

2. Nondiscrimination policy. Except as provided below, payment may not be made for inpatient or outpatient care provided and billed by an institutional provider found by the Federal Government to practice discrimination in the admission of patients to its services on the basis of race, color, or national origin. Reimbursement may not be made to a beneficiary who pays for care provided by such a facility and submits a claim for reimbursement. In the following circumstances, the Secretary of Defense, or a designee, may authorize payment for care obtained in an ineligible facility:

a. Emergency care. Emergency inpatient or outpatient care.

b. Care rendered before finding of a violation. Care initiated before a finding of a violation and which continues after such violation when it is determined that a change in the treatment facility would be detrimental to the health of the patient, and the attending physician so certifies.

c. Other facility not available. Care provided in an ineligible facility because an eligible facility is not available within a reasonable distance.

3. Procedures for qualifying as a CHAMPUS-approved institutional provider. General and special hospitals otherwise meeting the qualifications outlined in paragraphs B.4.a., b., and c., of this chapter are not required to request CHAMPUS approval formally.

a. JCAHO accreditation status. Each CHAMPUS fiscal intermediary shall keep informed as to the current JCAHO accreditation status of all hospitals and skilled nursing facilities in its area; and the provider's status under Medicare, particularly with regard to compliance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d(1)). The Director, OCHAMPUS, or a designee, shall specifically approve all other authorized institutional providers providing services to CHAMPUS beneficiaries. At the discretion of the Director, OCHAMPUS, any facility that is certified and participating as a provider of services under title XVIII of the Social Security Act (Medicare), may be deemed to meet CHAMPUS requirements. The facility must be providing a type and level of service that is authorized by this Regulation.

b. Required to comply with criteria. Facilities seeking CHAMPUS approval will be expected to comply with appropriate criteria set forth in subsection B.4. of this chapter. An onsite evaluation, either scheduled or unscheduled, may be conducted at the discretion of the Director, OCHAMPUS, or a designee. The final determination regarding approval, reapproval, or disapproval of a facility will be provided in writing to the facility and the appropriate CHAMPUS fiscal intermediary.

c. Notice of peer review rights. All health care facilities subject to the DRG-based payment system shall provide CHAMPUS beneficiaries, upon admission, with information about peer review including their appeal rights. The notices shall be in a form specified by the Director, OCHAMPUS.

d. Surveying of facilities. The surveying of newly established institutional providers and the periodic resurveying of all authorized institutional providers is a continuing process conducted by OCHAMPUS.

e. Institutions not in compliance with CHAMPUS standards. If a determination is made that an institution is not in compliance with one or more of the standards applicable to its specific category of institution, OCHAMPUS shall take immediate steps to bring about compliance or terminate the approval as an authorized institution in accordance with Chapter 9.F.2.

f. Participation agreements required for some hospitals which are not Medicare-participating. Notwithstanding the provisions of this paragraph B.3., a hospital which is subject to the CHAMPUS DRG-based payment system but which is not a Medicare-participating hospital must request and sign an agreement with OCHAMPUS. By signing the agreement, the hospital agrees to participate on all CHAMPUS inpatient claims and accept the requirements for a participating provider as contained in subsection A.7. of this chapter. Failure to sign such an agreement shall disqualify such hospital as a CHAMPUS-approved institutional provider.

4. Categories of institutional providers. The following categories of institutional providers may be reimbursed by CHAMPUS for services provided CHAMPUS beneficiaries subject to any and all definitions, conditions, limitations, and exclusions specified or enumerated in this Regulation.

a. Hospitals, acute care, general and special. An institution that provides inpatient services, that also may provide outpatient services (including clinical and ambulatory surgical services), and that:

(1) Is engaged primarily in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the medical or surgical diagnosis and treatment of illness, injury, or bodily malfunction (including maternity).

(2) Maintains clinical records on all inpatients (and outpatients if the facility operates an outpatient department or emergency room).

(3) Has bylaws in effect with respect to its operations and medical staff.

(4) Has a requirement that every patient be under the care of a physician.

(5) Provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times.

(6) Has in effect a hospital utilization review plan that is operational and functioning.

(7) In the case of an institution in a state in which state or applicable local law provides for the licensing of hospitals, the hospital:

(a) Is licensed pursuant to such law, or

(b) Is approved by the agency of such state or locality responsible for licensing hospitals as meeting the standards established for such licensing.

(8) Has in effect an operating plan and budget.

(9) Is accredited by the JCAHO or meets such other requirements as the Secretary of Health and Human Services or the Secretary of Defense finds necessary in the interest of the health and safety of patients who are admitted to and furnished services in the institution.

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b. Liver transplantation centers.

(1) CHAMPUS shall provide coverage for liver transplantation procedures performed only by experienced transplant surgeons at centers complying with the provisions outlined in paragraph B.4.a. of this section and meeting the following criteria:

(a) The center is a tertiary care facility affiliated with an academic health center. The center must have accredited programs in graduate medical education related to the function of liver transplantation such as internal medicine, pediatrics, surgery, and anesthesiology;

(b) The center has an active solid organ transplantation program (involving liver transplants as well as other organs);

(c) The transplantation center must have at least a 50 percent one-year survival rate for ten cases. At the time CHAMPUS approval is requested, the transplant center must provide evidence that at least ten liver transplants have been performed at the center and that at least 50 percent of those transplanted patients have survived one year following surgery. A 50 percent one-year survival rate for all subsequent liver transplantations must be maintained for continued CHAMPUS approval;

(d) The center has allocated sufficient operating room, recovery room, laboratory, and blood bank support and a sufficient number of intensive care and general surgical beds and specialized staff for these areas;

(e) The center participates in a donor procurement program and network;

(f) The center systematically collects and shares data on its transplant program;

(g) The center has an interdisciplinary body to determine the suitability of candidates for transplantation on an equitable basis;

(h) The transplantation surgeon is specifically trained for liver grafting and must assemble and train a team to function whenever a donor liver is available;

(i) The transplantation center must have on staff board eligible or board certified physicians and other experts in the field of hepatology, pediatrics, infectious disease, nephrology with dialysis capability, pulmonary medicine with respiratory therapy support, pathology, immunology, and anesthesiology to complement a qualified transplantation team;

(j) The transplantation center has the assistance of appropriate microbiology, clinical chemistry, and radiology support;

(k) The transplantation center has blood bank support to accommodate normal demands and the transplant procedure; and

(1) The transplantation center includes the availability of psychiatric and social services support for patients and family.

(2) In order to receive approval as a CHAMPUS authorized liver transplant center, a center must submit a request to the Director, OCHAMPUS, or a designee. The CHAMPUS authorized liver transplant center shall agree to the following:

(a) Bill for all services and supplies related to the liver transplantation performed by its staff and bill also for services rendered by the donor hospital following declaration of brain death and after all existing legal requirements for excision of the donor organ have been met; and

(b) The center shall agree to submit all charges on the basis of fully itemized bills. This means that each service and supply and the charge for each is individually identified.

c. Heart transplantation centers.

(1) CHAMPUS shall provide coverage for heart transplantation procedures performed only by experienced transplant surgeons at centers complying with provisions outlined in paragraph B.4.a. of this section and meeting the following criteria:

(a) The center has experts in the fields of cardiology, cardiovascular surgery, anesthesiology, immunology, infectious disease, nursing, social services and organ procurement to complement the transplant team;

(b) The center has an active cardiovascular medical and surgical program as evidenced by a minimum of 500 cardiac catheterizations and coronary arteriograms and 250 open heart procedures per year;

(c) The center has an anesthesia team that is available at all times;

(d) The center has infectious disease services with both the professional skills and the laboratory resources that are needed to discover, identify, and manage a whole range of organisms;

(e) The center has a nursing service team trained in the hemodynamic support of the patient and in managing immunosuppressed patients;

(f) The center has pathology resources that are available for studying and reporting the pathological responses of transplantation;

(g) The center has legal counsel familiar with transplantation laws and regulations;

(h) The commitment of the transplant center must be at all levels and broadly evident throughout the facility;

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(i) Responsible team members must be board certified or board eligible in their respective disciplines;

(j) Component teams must be integrated into a comprehensive transplant team with clearly defined leadership and responsibility;

(k) The center has adequate social service resources;

(l) The transplant center must comply with applicable State transplant laws and regulations;

(m) The transplant center must safeguard the rights and privacy of patients;

(n) The transplant center must have adequate patient management plans and protocols;

(o) The center participates in a donor procurement program and network;

(p) The center systematically collects and shares data on its transplant program;

(q) The center has an interdisciplinary body to determine the suitability of candidates for transplantation on an equitable basis;

(r) The center has extensive blood bank support;

(s) The center must have an established heart transplantation program with documented evidence of 12 or more heart transplants in each of the two consecutive preceding 12-month periods prior to application and 12 heart transplants prior to that; and

(t) The center must demonstrate actuarial survival rates of 73 percent for one year and 65 percent for two years for patients who have had heart transplants since January 1, 1982, at that facility.

(2) CHAMPUS approval will lapse if either the number of heart transplants falls below 8 in 12 months or if the one-year survival rate falls below 60 percent for a consecutive 24-month period.

(3) CHAMPUS-approval may also be extended for a heart transplant center that meets other certification or accreditation standards provided the standards are equivalent to or exceed the criteria listed above and have been approved by the Director, OCHAMPUS.

(4) In order to receive approval as a CHAMPUS heart transplant center, a facility must submit a request to the Director, OCHAMPUS, or a designee. The CHAMPUS-authorized heart transplant center shall agree to the following:

(a) Bill for all services and supplies related to the heart transplantation performed by its staff and bill also for services

rendered by the donor hospital following declaration of brain death;

(b) Submit all charges on the basis of fully itemized bills. Each service and supply must be individually identified and the first claim submitted for the heart transplantation must include a copy of the admission history and physical examination; and

(c) Report any significant decrease in the experience level or survival rates and loss of key members of the transplant team to the Director, OCHAMPUS.

d. Hospitals, psychiatric. A psychiatric hospital is an institution which is engaged primarily in providing services to inpatients for the diagnosis and treatment of mental disorders.

(1) There are two major categories of psychiatric hospitals:

(a) The private psychiatric hospital category includes both proprietary and the not-for-profit nongovernmental institutions.

(b) The second category is those psychiatric hospitals that are controlled, financed, and operated by departments or agencies of the local, state, or Federal Government and always are operated on a not-for-profit basis.

(2) In order for the services of a psychiatric hospital to be covered, the hospital shall comply with the provisions outlined in paragraph B.4.a. of this chapter. All psychiatric hospitals shall be accredited by

the JCAHO in order for their services to be cost-shared under CHAMPUS. In the case of those psychiatric hospitals that are not JCAHO-accredited because they have not been in operation a sufficient period of time to be eligible to request an accreditation survey by the JCAHO, the Director, OCHAMPUS, or a designee, may grant temporary approval if the hospital is certified and participating under Title XVIII of the Social Security Act (Medicare, Part A). This temporary approval expires 12 months from the date on which the psychiatric hospital first becomes eligible to request an accreditation survey by the JCAHO.

(3) Factors to be considered in determining whether CHAMPUS will cost-share care provided in a psychiatric hospital include, but are not limited to, the following considerations:

(a) Is the prognosis of the patient such that care provided will lead to resolution or remission of the mental illness to the degree that the patient is of no danger to others, can perform routine daily activities, and can be expected to function reasonably outside the inpatient setting?

(b) Can the services being provided be provided more economically in another facility or on an outpatient basis?

(c) Are the charges reasonable?

(d) Is the care primarily custodial or domiciliary?
(Custodial or domiciliary care of the permanently mentally ill or retarded is not a benefit under the Basic Program.)

e. Hospitals, long-term (tuberculosis, chronic care, or rehabilitation).
To be considered a long-term hospital, an institution for patients that have tuberculosis or chronic diseases must be an institution (or distinct part of an institution) primarily engaged in providing by or under the supervision of a physician appropriate medical or surgical services for the diagnosis and active treatment of the illness or condition in which the institution specializes.

(1) In order for the service of long-term hospitals to be covered, the hospital must comply with the provisions outlined in paragraph B.4.a. of this chapter. In addition, in order for services provided by such hospitals to be coverable by CHAMPUS, they must be primarily for the treatment of the presenting illness.

(2) Custodial or domiciliary care is not coverable under CHAMPUS, even if rendered in an otherwise authorized long-term hospital.

(3) The controlling factor in determining whether a beneficiary's stay in a long-term hospital is coverable by CHAMPUS is the level of professional care, supervision, and skilled nursing care that the beneficiary requires, in addition to the diagnosis, type of condition, or degree of functional limitations. The type and level of medical services required or rendered is controlling for purposes of extending CHAMPUS benefits: not the type of provider or condition of the beneficiary.

f. Skilled nursing facility. A skilled nursing facility is an institution (or a distinct part of an institution) that is engaged primarily in providing to inpatients medically necessary skilled nursing care, which is other than a nursing home or intermediate facility, and which:

(1) Has policies that are developed with the advice of (and with provisions for review on a periodic basis by) a group of professionals, including one or more physicians and one or more registered nurses, to govern the skilled nursing care and related medical services it provides.

(2) Has a physician, a registered nurse, or a medical staff responsible for the execution of such policies.

(3) Has a requirement that the medical care of each patient must be under the supervision of a physician, and provides for having a physician available to furnish necessary medical care in case of an emergency.

(4) Maintains clinical records on all patients.

(5) Provides 24-hour skilled nursing service that is sufficient to meet nursing needs in accordance with the policies developed as provided in subparagraph B.4.f.(1), above, and has at least one registered professional nurse employed full-time.

(6) Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals.

(7) Has in effect a utilization review plan that is operational and functioning.

(8) In the case of an institution in a state in which state or applicable local law provides for the licensing of this type facility, the institution:

(a) Is licensed pursuant to such law, or

(b) Is approved by the agency of such state or locality responsible for licensing such institutions as meeting the standards established for such licensing.

(9) Has in effect an operating plan and budget.

(10) Meets such provisions of the most current edition of the Life Safety Code (reference (dd)) as are applicable to nursing facilities; except that if the Secretary of Health and Human Services has waived, for such periods, as deemed appropriate, specific provisions of such code which, if rigidly applied, would result in unreasonable hardship upon a nursing facility.

g. Residential treatment centers. A residential treatment center (RTC) is a facility, or distinct part of a facility, that provides to children and adolescents under the age of 21, a total, 24-hour therapeutically planned group living and learning situation where distinct and individualized

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psychotherapeutic interventions can take place. Residential treatment is a specific level of care to be differentiated from acute, intermediate and long-term hospital care, where the least restrictive environment is maintained to allow for normalization of the patient's surroundings. The RTC must be both physically and programmatically distinct if it is a part or subunit of a larger treatment program. An RTC is organized and professionally staffed to provide residential treatment of mental disorders to children and adolescents who have sufficient intellectual potential to respond to active treatment (that is, for whom medical opinion or medical evidence can reasonably conclude that treatment of the mental disorder will result in an improved ability to function outside the RTC), for whom outpatient, partial hospitalization or other level of inpatient treatment is not appropriate, and for whom a protected and structured environment is medically or psychologically necessary.

(1) In order for the services of an RTC to be authorized, the RTC shall:

(a) Be accredited by the Joint Commission on Accreditation of Healthcare Organizations under the Consolidated Standards Manual for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities and Facilities Serving the Mentally Retarded;

(b) Comply with the CHAMPUS Standards for Residential Treatment Centers Serving Children and Adolescents with Mental Disorders, as issued by the Director, OCHAMPUS;

(c) Have entered into a Participation Agreement with OCHAMPUS within which the RTC agrees, in part, to:

1 Render residential treatment center inpatient services to eligible CHAMPUS beneficiaries in need of such services, in accordance with the participation agreement and the CHAMPUS regulation;

2 Accept payment for its services based upon the methodology provided in Chapter 14, paragraph E, or such other method as determined by the Director, OCHAMPUS;

3 Accept the CHAMPUS all-inclusive per diem rate as payment in full and collect from the CHAMPUS beneficiary or the family of the CHAMPUS beneficiary only those amounts that represent the beneficiary's liability, as defined in Chapter 4, and charges for services and supplies that are not a benefit of CHAMPUS;

4 Make all reasonable efforts acceptable to the Director, OCHAMPUS, to collect those amounts which represent the beneficiary's liability, as defined in Chapter 4;

5 Comply with the provisions of Chapter 8, and submit claims first to all health insurance coverage to which the beneficiary is entitled that is primary to CHAMPUS;

6 Submit claims for services provided to CHAMPUS beneficiaries at least every 30 days. If claims are not submitted at least every 30 days, the RTC agrees not to bill the beneficiary or the beneficiary's family any amounts disallowed by CHAMPUS;

7 Designate an individual who will act as liaison for CHAMPUS inquiries. The RTC shall inform OCHAMPUS in writing of the designated individual;

8 Furnish OCHAMPUS with cost data certified to by an independent accounting firm or other agency as authorized by the Director, OCHAMPUS;

9 Grant the Director, OCHAMPUS, or designee, the right to conduct quality assurance audits or accounting audits with full access to patients and records to determine the quality and cost-effectiveness of care rendered. The audits may be conducted on a scheduled or unscheduled (unannounced) basis. This right to audit/review includes, but is not limited to:

a Examination of fiscal and all other records of the RTC which would confirm compliance with the participation agreement and designation as an authorized CHAMPUS RTC provider;

b Conducting such audits of RTC records including clinical, financial, and census records, as may be necessary to determine the nature of the services being provided, and the basis for charges and claims against the United States for services provided CHAMPUS beneficiaries;

c Examining reports of evaluations and inspections conducted by federal, state and local government, and private agencies and organizations;

d Conducting on-site inspections of the facilities of the RTC and interviewing employees, members of the staff, contractors, board members, volunteers, and patients, as required;

e Audits conducted by the United States General Accounting Office.

(d) Be licensed and operational for a minimum period of six months.

(2) The RTC shall not be considered to be a CHAMPUS-authorized provider and CHAMPUS benefits shall not be paid for services provided by the RTC until the date the participation agreement is signed by the Director, OCHAMPUS, or a designee.

(3) Even though an RTC may qualify as a CHAMPUS-authorized provider and may have entered into a participation agreement with CHAMPUS, payment by CHAMPUS for a particular admission is contingent upon certain conditions:

(a) The child seeking admission is suffering from a mental disorder which meets the diagnostic criteria of the DSM-III and meets the CHAMPUS definition of a mental disorder in Chapter 2.

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- (b) The child meets the criteria for admission to an RTC issued by the Director, OCHAMPUS.
 - (c) A psychiatrist or other physician or a clinical psychologist shall recommend that the child be admitted to the RTC.
 - (d) A psychiatrist or a clinical psychologist shall direct the development of the child's treatment plan.
 - (e) All services shall be provided by or under the supervision of a qualified mental health provider (refer to paragraph C.3.i. of Chapter 4).
 - (f) The child's admission to the RTC is authorized by CHAMPUS, or a designee.
- (4) Under the terms of the participation agreement, RTCs must provide the following safeguards for continued benefit access and quality of care:

- (a) Assure that any and all eligible beneficiaries receive care which complies with standards in paragraphs B.4.g.(1)(a) through (d) and B.4.g.(3);
- (b) Provide inpatient services to CHAMPUS beneficiaries in the same manner it provides inpatient services to all other patients;
- (c) Not discriminate against CHAMPUS beneficiaries in any manner, including admission practices, placement in special or separate wings or rooms, or provisions of special or limited treatment.

h. Christian Science sanatoriums. The services obtained in Christian Science sanatoriums are covered by CHAMPUS as inpatient care. To qualify for coverage, the sanatorium either must be operated by, or be listed and certified by the First Church of Christ, Scientist.

i. Infirmaries. Infirmaries are facilities operated by student health departments of colleges and universities to provide inpatient or outpatient care to enrolled students. Charges for care provided by such facilities will not be cost-shared by CHAMPUS if the student would not be charged in the absence of CHAMPUS, or if student is covered by a mandatory student health insurance plan, in which enrollment is required as a part of the student's school registration and the charges by the college or university include a premium for the student health insurance coverage. CHAMPUS will cost-share only if enrollment in the student health program or health insurance plan is voluntary.

NOTE: An infirmary in a boarding school also may qualify under this provision, subject to review and approval by the Director, OCHAMPUS, or a designee.

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j. Other STF's

(1) General

(a) Care provided by certain STF's (on either an inpatient or outpatient basis), other than those listed above, may be cost-shared by CHAMPUS under specified circumstances.

1 The course of treatment is prescribed by a doctor of medicine or osteopathy.

2 The patient is under the supervision of a physician during the entire course of the inpatient admission or the outpatient treatment.

3 The type and level of care and service rendered by the institution are otherwise authorized by this Regulation.

4 The facility meets all licensing or other certification requirements that are extant in the jurisdiction in which the facility is located geographically.

5 Is other than a nursing home, intermediate care facility, home for the aged, halfway house, or other similar institution.

6 Is accredited by the JCAHO or other CHAMPUS-approved accreditation organization, if an appropriate accreditation program for the given type of facility is available. As future accreditation programs are developed to cover emerging specialized treatment programs, such accreditation will be a prerequisite to coverage by CHAMPUS for services provided by such facilities.

(b) To ensure that CHAMPUS beneficiaries are provided quality care at a reasonable cost when treated by a STF, the Director, OCHAMPUS, or a designee, will retain the right to:

1 Require prior approval of all admissions to specialized inpatient treatment facilities.

2 Set appropriate standards for STF's in addition to or in the absence of JCAHO accreditation.

3 Monitor facility operations and treatment programs on a continuing basis and conduct onsite inspections on a scheduled and unscheduled basis.

4 Negotiate agreements of participation.

5 Terminate approval of a case when it is ascertained that a departure from the facts upon which the admission was based originally has occurred.

6 Declare an STF not eligible for CHAMPUS payment if that facility has been found to have engaged in fraudulent or deceptive practices.

(c) In general, the following disclaimers apply to treatment by STFs:

1 Just because one period or episode of treatment by a facility has been covered by CHAMPUS may not be construed to mean that later episodes of care by the same or similar facility will be covered automatically.

2 The fact that one case has been authorized for treatment by a specific facility or similar type of facility may not be construed to mean that similar cases or later periods of treatment will be extended CHAMPUS benefits automatically.

(2) Types of providers. The following is a list of facilities that have been designated specifically as STFs. The list is for example only and is not to be construed as being all-inclusive.

(a) Free-standing ambulatory surgical centers. Care provided by freestanding ambulatory surgical centers may be cost-shared by CHAMPUS under the following circumstances:

1 The treatment is prescribed and supervised by a physician.

2 The type and level of care and services rendered by the center are otherwise authorized by this Regulation.

3 The center meets all licensing or other certification requirements of the jurisdiction in which the facility is located.

4 The center is accredited by the JCAHO, the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), or such other standards as authorized by the Director, OCHAMPUS.

5 A childbirth procedure provided by a CHAMPUS-approved free-standing ambulatory surgical center shall not be cost-shared by CHAMPUS unless the surgical center is also a CHAMPUS-approved birthing center institutional provider as established by the birthing center provider certification requirement of this Regulation.

(b) PFTH facilities. STFs also include facilities that seek approval to provide care authorized under the PFTH. (Refer to Chapter 5 of this Regulation.)

(c) Alcohol rehabilitation facilities. In order to be authorized under CHAMPUS as a provider of alcohol detoxification, rehabilitative services, outpatient treatment, and family therapy, alcohol rehabilitation facilities, both freestanding facilities and hospital-based facilities, shall operate primarily for the purpose of providing alcoholism treatment (on either an inpatient (including partial care) or an outpatient basis) and shall meet the following criteria:

1 The course of treatment shall be prescribed by and supervised by a qualified mental health provider (refer to Chapter 4, paragraph C.3.i.) practicing within the scope of his or her license. When indicated by the patient's physical status, the patient shall be under the general supervision of a physician.

2 The type and level of care provided by the facility are otherwise authorized by this Regulation.

3 The facility shall meet all licensing and other certification requirements of the jurisdiction in which the facility is located.

4 The facility shall be accredited by the JCAHO or shall meet such other requirements as the Director, OCHAMPUS, finds necessary in the interest of the health and safety of the individuals who are furnished services in the facility.

5 The facility shall have entered into a participation agreement with OCHAMPUS within which the facility agrees, in part, to:

a Accept payment for its services based on an allowable-cost rate acceptable to the Director, OCHAMPUS, or such other method as determined by the Director, OCHAMPUS;

b Furnish OCHAMPUS with cost data certified to by an independent accounting firm or other agency as authorized by the Director, OCHAMPUS;

c Accept the CHAMPUS-determined rate as payment in full and to collect from the CHAMPUS beneficiary those amounts that represent the beneficiary's liability, as defined in Chapter 4, and charges for services and supplies that are not a benefit of CHAMPUS;

d Make all reasonable efforts acceptable to the Director, OCHAMPUS, to collect those amounts which represent the beneficiary's liability, as defined in Chapter 4;

e Permit access by the Director, OCHAMPUS, to clinical records of CHAMPUS beneficiaries and to the financial and organizational records of the facility;

f Comply with the provisions of Chapter 8, and to submit claims first to all health insurance coverage to which the beneficiary is entitled that is primary to CHAMPUS.

6 The alcoholism rehabilitation facility shall not be considered to be a CHAMPUS-authorized provider and CHAMPUS benefits shall not be paid for services provided by the alcoholism rehabilitation facility until the date the participation agreement is signed by the Director, OCHAMPUS, or a designee.

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NOTE: Each alcoholism rehabilitation facility shall enter into a participation agreement as described in subparagraph B.4.j.(2)(c)5 above, by October 1, 1985. An alcoholism rehabilitation facility that was a CHAMPUS-authorized provider as of September 14, 1984, and that otherwise meets the requirements of subparagraphs B.4.j.(2)(c)1 through 4 will continue to be authorized until the participation agreement is signed on October 1, 1985, whichever occurs first.

k. Birth centers. A birthing center is a freestanding or institution-affiliated outpatient maternity care program which principally provides a planned course of outpatient prenatal care and outpatient childbirth service limited to low-risk pregnancies; excludes care for high-risk pregnancies; limits childbirth to the use of natural childbirth procedures; and provides immediate newborn care.

(1) Certification requirements. A birthing center which meets the following criteria may be designated as an authorized CHAMPUS institutional provider:

(a) The predominant type of service and level of care rendered by the center is otherwise authorized by this Regulation.

(b) The center is licensed to operate as a birthing center where such license is available, or is specifically licensed as a type of ambulatory health care facility where birthing center specific license is not available, and meets all applicable licensing or certification requirements that are extant in the state, county, municipality, or other political jurisdiction in which the center is located.

(c) The center is accredited by a nationally recognized accreditation organization whose standards and procedures have been determined to be acceptable by the Director, OCHAMPUS, or a designee.

(d) The center complies with the CHAMPUS birthing center standards set forth in this Chapter.

(e) The center has entered into a participation agreement with OCHAMPUS in which the center agrees, in part, to:

1 Participate in CHAMPUS and accept payment for maternity services based upon the reimbursement methodology for birthing centers;

2 Collect from the CHAMPUS beneficiary only those amounts that represent the beneficiary's liability under the participation agreement and the reimbursement methodology for birthing centers, and the amounts for services and supplies that are not a benefit of the CHAMPUS;

3 Permit access by the Director, OCHAMPUS, or a designee, to the clinical record of any CHAMPUS beneficiary, to the

financial and organizational records of the center, and to reports of evaluations and inspections conducted by state or private agencies or organizations;

4 Submit claims first to all health benefit and insurance plans primary the CHAMPUS to which the beneficiary is entitled and to comply with the double coverage provisions of this Regulation.

5 Notify OCHAMPUS in writing within 7 days of the emergency transport of any CHAMPUS beneficiary from the center to an acute care hospital or of the death of any CHAMPUS beneficiary in the center.

(f) A birthing center shall not be a CHAMPUS-authorized institutional provider and CHAMPUS benefits shall not be paid for any service provided by a birthing center before the date the participation agreement is signed by the Director, OCHAMPUS, or a designee.

(2) CHAMPUS birthing center standards.

(a) Environment. The center has a safe and sanitary environment, properly constructed, equipped, and maintained to protect health and safety and meets the applicable provisions of the "Life Safety Code" of the National Fire Protection Association.

(b) Policies and procedures. The center has written administrative, fiscal, personnel and clinical policies and procedures which collectively promote the provision of high-quality maternity care and childbirth services in an orderly, effective, and safe physical and organizational environment.

(c) Informed consent. Each CHAMPUS beneficiary admitted to the center will be informed in writing at the time of admission of the nature and scope of the center's program and of the possible risks associated with maternity care and childbirth in the center.

(d) Beneficiary care. Each woman admitted will be cared for by or under the direct supervision of a specific physician or a specific certified nurse-midwife who is otherwise eligible as a CHAMPUS individual professional provider.

(e) Medical direction. The center has written memoranda of understanding (MOU) for routine consultation and emergency care with an obstetrician-gynecologist who is certified or is eligible for certification by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology and with a pediatrician who is certified or eligible for certification by the American Board of Pediatrics or by the American Osteopathic Board of Pediatrics, each of whom have admitting privileges to at least one back-up hospital. In lieu of a required MOU, the center may employ a physician with the required qualifications. Each MOU must be renewed annually.

(f) Admission and emergency care criteria and procedures. The center has written clinical criteria and administrative procedures, which are reviewed and approved annually by a physician related to the center as required by subparagraph (e) above, for the exclusion of a woman with a high-risk pregnancy from center care and for management of maternal and neonatal emergencies.

(g) Emergency treatment. The center has a written memorandum of understanding (MOU) with at least one backup hospital which documents that the hospital will accept and treat any woman or newborn transferred from the center who is in need of emergency obstetrical or neonatal medical care. In lieu of this MOU with a hospital, a birthing center may have an MOU with a physician, who otherwise meets the requirements as a CHAMPUS individual professional provider, and who has admitting privileges to a back-up hospital capable of providing care for critical maternal and neonatal patients as demonstrated by a letter from that hospital certifying the scope and expected duration of the admitting privileges granted by the hospital to the physician. The MOU must be renewed annually.

(h) Emergency medical transportation. The center has a written memorandum of understanding (MOU) with at least one ambulance service which documents that the ambulance service is routinely staffed by qualified personnel who are capable of the management of critical maternal and neonatal patients during transport and which specifies the estimated transport time to each backup hospital with which the center has arranged for emergency treatment as required in subparagraph (g) above. Each MOU must be renewed annually.

(i) Professional staff. The center's professional staff is legally and professionally qualified for the performance of their professional responsibilities.

(j) Medical records. The center maintains full and complete written documentation of the services rendered to each woman admitted and each newborn delivered. A copy of the informed consent document required by subparagraph (c), above, which contains the original signature of the CHAMPUS beneficiary, signed and dated at the time of admission, must be maintained in the medical record of each CHAMPUS beneficiary admitted.

(k) Quality assurance. The center has an organized program for quality assurance which includes, but is not limited to, written procedures for regularly scheduled evaluation of each type of service provided, of each mother or newborn transferred to a hospital, and of each death within the facility.

(l) Governance and administration. The center has a governing body legally responsible for overall operation and maintenance of the center and a full-time employee who has authority and responsibility for the day-to-day operation of the center.

C. INDIVIDUAL PROFESSIONAL PROVIDERS OF CARE

1. General. Individual professional providers of care are those providers who bill for their services on a fee-for-service basis and are not employed or contracted with by an institutional provider. This category also includes those individuals who have formed professional corporations or associations qualifying as a domestic corporation under section 301.7701-5 of the Internal Revenue Service Regulations (reference (cc)). Such individual professional providers must be licensed or certified by the local licensing or certifying agency for the jurisdiction in which the care is provided; or in the absence of state licensure/certification, be a member of or demonstrate eligibility for full clinical membership in, the appropriate national or professional certifying association that sets standards for the profession of which the provider is a member. Services provided must be in accordance with good medical practice and prevailing standards of quality of care and within recognized utilization norms.

a. Licensing/Certification required, scope of license. Otherwise covered services shall be cost-shared only if the individual professional provider holds a current, valid license or certification to practice his or her profession in the jurisdiction where the service is rendered. Licensure/certification must be at the full clinical practice level. The services provided must be within the scope of the license, certification or other legal authorization. Licensure or certification is required to be a CHAMPUS authorized provider if offered in the jurisdiction where the service is rendered, whether such licensure or certification is required by law or provided on a voluntary basis. The requirement also applies for those categories of providers that would otherwise be exempt by the state because the provider is working in a non-profit, state-owned or church setting. Licensure/certification is mandatory for a provider to become a CHAMPUS-authorized provider.

b. Monitoring required. The Director, OCHAMPUS, or a designee, shall develop appropriate monitoring programs and issue guidelines, criteria, or norms necessary to ensure that CHAMPUS expenditures are limited to necessary medical supplies and services at the most reasonable cost to the government and beneficiary. The Director, OCHAMPUS, or a designee, also will take such steps as necessary to deter overutilization of services.

c. Christian Science. Christian Science practitioners and Christian Science nurses are authorized to provide services under CHAMPUS. Inasmuch as they provide services of an extramedical nature, the general criteria outlined above do not apply to Christian Science services (refer to subparagraph C.3.d.(2), below, regarding services of Christian Science practitioners and nurses).

d. Physician referral and supervision. Physician referral and supervision is required for the services of paramedical providers as listed in subparagraph C.3.c.8. and for marriage and family counselors, pastoral counselors, and mental health counselors. Physician referral means that the physician must actually see the patient, perform an evaluation, and arrive at an initial diagnostic impression prior to referring the patient. Documentation is required of the physician's examination, diagnostic impression, and referral. Physician supervision means that the physician provides overall medical management of the case. The physician does not have to be physically located on the premises of the provider to whom the referral is made. Communication back to the referring physician is an indication of medical management.

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2. Interns and residents. Interns and residents may not be paid directly by CHAMPUS for services rendered to a beneficiary when their services are provided as part of their employment (either salaried or contractual) by a hospital or other institutional provider.

3. Types of providers. Subject to the standards of participation provisions of this Regulation, the following individual professional providers of medical care are authorized to provide services to CHAMPUS beneficiaries:

a. Physicians

- (1) Doctors of Medicine (M.D.).
- (2) Doctors of Osteopathy (D.O.).

b. Dentists. Except for covered oral surgery as specified in section E. of Chapter 4 of this Regulation, all otherwise covered services rendered by dentists require preauthorization.

- (1) Doctors of Dental Medicine (D.M.D.).
- (2) Doctors of Dental Surgery (D.D.S.).

c. Other allied health professionals. The services of the following individual professional providers of care are coverable on a fee-for-service basis provided such services are otherwise authorized in this or other chapters of this Regulation.

(1) Clinical psychologist. For purposes of CHAMPUS, a clinical psychologist is an individual who is licensed or certified by the state for the independent practice of psychology and:

(a) Possesses a doctoral degree in psychology from a regionally accredited university; and

(b) Has had 2 years of supervised clinical experience in psychological health services of which at least 1 year is post-doctoral and 1 year (may be the post-doctoral year) is in an organized psychological health service training program; or

(c) As an alternative to (a) and (b) above, is listed in the National Register of Health Service Providers in Psychology (reference (ee)).

- (2) Doctors of Optometry.
- (3) Doctors of Podiatry or Surgical Chiropody.
- (4) Certified nurse midwives.

(a) A certified nurse midwife may provide covered care independent of physician referral and supervision, provided the nurse midwife is:

1 Licensed, when required, by the local licensing agency for the jurisdiction in which the care is provided; and

2 Certified by the American College of Nurse Midwives. To receive certification, a candidate must be a registered nurse who has completed successfully an educational program approved by the American College of Nurse Midwives, and passed the American College of Nurse Midwives National Certification Examination.

(b) The services of a registered nurse who is not a certified nurse midwife may be authorized only when the patient has been referred for care by a licensed physician and a licensed physician provides continuing supervision of the course of care. A lay midwife who is neither a certified nurse midwife nor a registered nurse is not a CHAMPUS-authorized provider, regardless of whether the services rendered may otherwise be covered.

(5) Certified nurse practitioner. Within the scope of applicable licensure or certification requirements, a certified nurse practitioner may provide covered care independent of physician referral and supervision, provided the nurse practitioner is:

(a) A licensed, registered nurse; and

(b) Specifically licensed or certified as a nurse practitioner by the state in which the care was provided, if the state offers such specific licensure or certification; or

(c) Certified as a nurse practitioner (certified nurse) by a professional organization offering certification in the speciality of practice, if the state does not offer specific licensure or certification for nurse practitioners.

(6) Certified Clinical Social Worker. A clinical social worker may provide covered services independent of physician referral and supervision, provided the clinical social worker:

(a) Is licensed or certified as a clinical social worker by the jurisdiction where practicing; or, if the jurisdiction does not provide for licensure or certification of clinical social workers, is certified by a national professional organization offering certification of clinical social workers; and

(b) Has at least a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education; and

(c) Has had a minimum of 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting, as determined by the Director, OCHAMPUS, or a designee.

NOTE: Patients' organic medical problems must receive appropriate concurrent management by a physician.

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(7) Certified psychiatric nurse specialist. A certified psychiatric nurse specialist may provide covered care independent of physician referral and supervision. For purposes of CHAMPUS, a certified psychiatric nurse specialist is an individual who:

(a) Is a licensed, registered nurse; and

(b) Has at least a master's degree in nursing from a regionally accredited institution with a specialization in psychiatric and mental health nursing; and

(c) Has had at least 2 years of post-master's degree practice in the field of psychiatric and mental health nursing, including an average of 8 hours of direct patient contact per week; or

(d) Is listed in a CHAMPUS-recognized, professionally sanctioned listing of clinical specialists in psychiatric and mental health nursing.

(8) Certified physician assistant. A physician assistant may provide care under general supervision of a physician (see Chapter 14 G.I.C. for limitations on reimbursement). For purposes of CHAMPUS, a physician assistant must meet the applicable state requirements governing the qualifications of physician assistants and at least one of the following conditions:

(a) Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians, or

(b) Has satisfactorily completed a program for preparing physician assistants that:

1 Was at least 1 academic year in length;

2 Consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and

3 Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or

(c) Has satisfactorily completed a formal educational program for preparing physician assistants that does not meet the requirements of subparagraph (1)(b) of this paragraph and had been assisting primary care physicians for a minimum of 12 months during the 18-month period immediately preceding January 1, 1987.

(9) Other individual paramedical providers. The services of the following individual professional providers of care to be considered for benefits on a fee-for-service basis may be provided only if the beneficiary is referred by a physician for the treatment of a medically-diagnosed condition and a physician must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by these individual paramedical providers.

- (a) Licensed registered nurses.
- (b) Licensed practical or vocational nurses.
- (c) Licensed registered physical therapists.
- (d) Audiologists.
- (e) Speech therapists (speech pathologists).

d. Extramedical individual providers. Extramedical individual providers are those who do counseling or nonmedical therapy and whose training and therapeutic concepts are outside the medical field.

(1) Marriage and family counselors, pastoral counselors, and mental health counselors. The services of certain extramedical marriage and family counselors, pastoral counselors, and mental health counselors are coverable on a fee-for-service basis, under the following specified conditions:

(a) The CHAMPUS beneficiary must be referred for therapy by a physician.

(b) A physician is providing ongoing oversight and supervision of the therapy being provided.

(c) The marriage and family counselor, pastoral counselor, and mental health counselor must certify on each claim for reimbursement that a written communication has been made or will be made to the referring physician of the results of the treatment. Such communication will be made at the end of the treatment, or more frequently, as required by the referring physician (refer to chapter 7).

(d) Marriage and family counselors and pastoral counselors shall have the following:

1 Recognized graduate professional education with the minimum of an earned master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline.

2 The following experience:

a Either 200 hours of approved supervision in the practice of marriage and family counseling or pastoral counseling, ordinarily to be completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases, and

b 1,000 hours of clinical experience in the practice of marriage and family counseling or pastoral counseling under approved supervision, involving at least 50 different cases; or

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c 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling or pastoral counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years, and

d 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in marriage and family counseling or pastoral counseling under approved supervision, involving at least 20 cases, and

(e) Mental health counselors shall have the following:

1 Minimum of a master's degree in mental health counseling or allied mental health field from a regionally accredited institution, and

2 Two years of post-master's experience which includes 3000 hours of clinical work and 100 hours of face-to-face supervision.

(f) These providers must also be licensed or certified to practice as a marriage and family counselor, pastoral counselor or mental health counselor by the jurisdiction where practicing. If specific licensure is not available in the state, then licensure under general provisions, where available, is required. If the jurisdiction does not provide for licensure or certification either in a specific or general counselor category, the provider must be certified by or eligible for full clinical membership in the appropriate national professional association that sets standards for the specific profession.

(g) Grace period for counselors in states where licensure/certification is optional. CHAMPUS is providing a grace period for those counselors who did not obtain optional licensure/certification in their jurisdiction, not realizing it was a CHAMPUS requirement for authorization. The exemption by state law for pastoral counselors may have misled this group into thinking licensure was not required. The same situation may have occurred with the other counselor categories where licensure was either not mandated by the state or was provided under a more general category such as "professional counselors." This grace period only pertains to the licensure/certification requirement, applies only to counselors who are already approved as of October 29, 1990, and only in those areas where the licensure/certification is optional. Any counselor who is not licensed/certified in the state in which he/she is practicing by August 1, 1991, will be terminated under the provisions of Chapter 9 of this Regulation. This grace period does not change any of the other existing requirements which remain in effect. During this grace period, membership or proof of eligibility for full clinical membership in a recognized professional association is required for those counselors who are not licensed or certified by the state. The following organizations are recognized for counselors at the level indicated: full clinical member of the American Association of Marriage and Family Counselors; membership at the fellow or diplomate level of the American Association of Pastoral Counselors; and membership in the National Academy of Certified Clinical Mental Health Counselors. Acceptable proof of eligibility for membership is a letter from the appropriate certifying organization. This opportunity for delayed

certification/licensure is limited to the counselor category only as the language in all of the other provider categories has been consistent and unmodified from the time each of the other provider categories were added. The grace period does not apply in those states where licensure is mandatory.

(2) Christian Science practitioners and Christian Science nurses. CHAMPUS cost shares the services of Christian Science practitioners and nurses. In order to bill as such, practitioners or nurses must be listed or be eligible for listing in the Christian Science Journal at the time the service is provided.

D. OTHER PROVIDERS

Certain medical supplies and services of an ancillary or supplemental nature are coverable by CHAMPUS, subject to certain controls. This category of provider includes the following:

1. Independent laboratory. Laboratory services of independent laboratories may be cost-shared if the laboratory is approved for participation under Medicare and certified by the Medicare Bureau, Health Care Financing Administration.

2. Suppliers of portable x-ray services. Such suppliers must meet the conditions of coverage of the Medicare program, set forth in the Medicare regulations (reference (h)), or the Medicaid program in that state in which the covered service is provided.

3. Pharmacies. Pharmacies must meet the applicable requirements of state law in the state in which the pharmacy is located.

4. Ambulance companies. Such companies must meet the requirements of state and local laws in the jurisdiction in which the ambulance firm is licensed.

5. Medical equipment firms, medical supply firms. As determined by the Director, OCHAMPUS, or a designee.

E. IMPLEMENTING INSTRUCTIONS

The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this chapter.

F. EXCLUSION

Regardless of any provision in this chapter, a provider who is suspended, excluded, or terminated under Chapter 9 of this Regulation is specifically excluded as an authorized CHAMPUS provider.

CHAPTER 7

CLAIMS SUBMISSION, REVIEW, AND PAYMENT

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CHAPTER 7
CLAIMS SUBMISSION, REVIEW, AND PAYMENT

A. GENERAL

The Director, OCHAMPUS, or a designee, is responsible for ensuring that benefits under CHAMPUS are paid only to the extent described in this Regulation. Before benefits can be paid, an appropriate claim must be submitted that includes sufficient information as to beneficiary identification, the medical services and supplies provided, and double coverage information, to permit proper, accurate, and timely adjudication of the claim by the CHAMPUS fiscal intermediary or OCHAMPUS. Subject to such definitions, conditions, limitations, exclusions, and requirements as may be set forth in this Regulation, the following are the CHAMPUS claim filing requirements:

1. CHAMPUS identification card required. A patient shall present his or her applicable CHAMPUS identification card (that is, Uniformed Services identification card) to the authorized provider of care that identifies the patient as an eligible CHAMPUS beneficiary (refer to Chapter 3 of this Regulation).

2. Claim required. No benefit may be extended under the Basic Program or PFTH without the submission of a complete and properly executed appropriate claim form.

3. Responsibility for perfecting claim. It is the responsibility of the CHAMPUS beneficiary or sponsor or the authorized provider acting on behalf of the CHAMPUS beneficiary to perfect a claim for submission to the appropriate CHAMPUS fiscal intermediary. Neither a CHAMPUS fiscal intermediary nor OCHAMPUS is authorized to prepare a claim on behalf of a CHAMPUS beneficiary.

4. Obtaining appropriate claim form. CHAMPUS provides specific CHAMPUS forms appropriate for making a claim for benefits for various types of medical services and supplies (such as hospital, physician, or prescription drugs). Claim forms may be obtained from the appropriate CHAMPUS fiscal intermediary who processes claims for the beneficiary's state of residence, from the Director, OCHAMPUS, or a designee, or from CHAMPUS health benefits advisors (HBAs) located at all Uniformed Services medical facilities.

5. Prepayment not required. A CHAMPUS beneficiary or sponsor is not required to pay for the medical services or supplies before submitting a claim for benefits.

6. Deductible certificate. If the fiscal year outpatient deductible has been met by a beneficiary (\$50) or a family (\$100 aggregate) through the submission of a claim or claims to a CHAMPUS fiscal intermediary in a geographic location different from the location where a current claim is being submitted, the beneficiary or sponsor must obtain a deductible certificate from the CHAMPUS fiscal intermediary where the applicable individual or family fiscal year deductible was met. Such deductible certificate must be attached to the current claim being submitted for benefits. Failure to obtain a deductible certificate under such circumstances will result in a second individual or

family fiscal year deductible being applied. However, this second deductible may be reimbursed once appropriate documentation, as described in this subsection A.6., is supplied to the CHAMPUS fiscal intermediary applying the second deductible (refer to section F. of Chapter 4 of this Regulation).

7. Nonavailability Statement (DD Form 1251). In some geographic locations or under certain circumstances, it is necessary for a CHAMPUS beneficiary to determine whether the required medical care can be provided through a Uniformed Services facility. If the required medical care cannot be provided by the Uniformed Services facility, a Nonavailability Statement will be issued. When required (except for emergencies), this Nonavailability Statement must be issued before medical care is obtained from civilian sources. Failure to secure such a statement will waive the beneficiary's rights to benefits under CHAMPUS, subject to appeal to the appropriate hospital commander (or higher medical authority).

a. Rules applicable to issuance of Nonavailability Statement. The ASD(HA) has issued DoD Instruction 6015.19 (reference (gg)) that contains rules for the issuance of Nonavailability Statements. Such rules may change depending on the current situations.

b. Beneficiary responsibility. The beneficiary shall ascertain whether or not he or she resides in a geographic area that requires obtaining a Nonavailability Statement. Information concerning current rules may be obtained from the CHAMPUS fiscal intermediary concerned, a CHAMPUS HBA or the Director, OCHAMPUS, or a designee.

c. Rules in effect at time civilian care is provided apply. The applicable rules regarding Nonavailability Statements in effect at the time the civilian care is rendered apply in determining whether a Nonavailability Statement is required.

d. Nonavailability Statement must be filed with applicable claim. When a claim is submitted for CHAMPUS benefits that includes services for which a Nonavailability Statement is required, such statement must be submitted along with the claim form.

B. INFORMATION REQUIRED TO ADJUDICATE A CHAMPUS CLAIM

Claims received that are not completed fully and that do not provide the following minimum information may be returned. If enough space is not available on the appropriate claim form, the required information must be attached separately and include the patient's name and address, be dated, and signed.

1. Patient's identification information. The following patient identification information must be completed on every CHAMPUS claim form submitted for benefits before a claim will be adjudicated and processed:

- a. Patient's full name.
- b. Patient's residence address.
- c. Patient's date of birth.

d. Patient's relationship to sponsor.

NOTE: If name of patient is different from sponsor, explain (for example, stepchild or illegitimate child).

e. Patient's identification number (from DD Form 1173).

f. Patient's identification card effective date and expiration date (from DD Form 1173).

g. Sponsor's full name.

h. Sponsor's service or social security number.

i. Sponsor's grade.

j. Sponsor's organization and duty station. Home port for ships; home address for retiree.

k. Sponsor's branch of service or deceased or retiree's former branch of service.

2. Sponsor's current status. Active duty, retired, or deceased.

3. Patient treatment information. The following patient treatment information routinely is required relative to the medical services and supplies for which a claim for benefits is being made before a claim will be adjudicated and processed:

a. Diagnosis. All applicable diagnoses are required; standard nomenclature is acceptable. In the absence of a diagnosis, a narrative description of the definitive set of symptoms for which the medical care was rendered must be provided.

b. Source of care. Full name of source of care (such as hospital or physician) providing the specific medical services being claimed.

c. Full address of source of care. This address must be where the care actually was provided, not a billing address.

d. Attending physician. Name of attending physician (or other authorized individual professional provider).

e. Referring physician. Name and address of ordering, prescribing, or referring physician.

f. Status of patient. Status of patient at the time the medical services and supplies were rendered (that is, inpatient or outpatient).

g. Dates of service. Specific and inclusive dates of service.

h. Inpatient stay. Source and dates of related inpatient stay (if applicable).

i. Physicians or other authorized individual professional providers. For services provided by physicians (or other authorized individual professional providers), the following information also must be included:

- (1) Date of each service.
- (2) Procedure code or narrative description of each procedure or service for each date of service.
- (3) Individual charge for each item of service or each supply for each date.
- (4) Detailed description of any unusual complicating circumstances related to the medical care provided that the physician or other individual professional provider may choose to submit separately.

j. Hospitals or other authorized institutional providers. For care provided by hospitals (or other authorized institutional providers), the following information also must be provided before a claim will be adjudicated and processed:

- (1) An itemized billing showing each item of service or supply provided for each day covered by the claim.

NOTE: The Director, OCHAMPUS, or a designee, may approve, in writing, an alternate billing procedure for RTCs or other special institutions, in which case the itemized billing requirement may be waived. The particular facility will be aware of such approved alternate billing procedure.

- (2) Any absences from a hospital or other authorized institution during a period for which inpatient benefits are being claimed must be identified specifically as to date or dates and provide details on the purpose of the absence. Failure to provide such information will result in denial of benefits and, in an ongoing case, termination of benefits for the inpatient stay at least back to the date of the absence.

(3) For hospitals subject to the CHAMPUS DRG-based payment system (see subparagraph A.1.b.(4) of Chapter 14), the following information is also required:

(a) The principal diagnosis (the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital).

- (b) All secondary diagnoses.
- (c) All procedures performed.
- (d) The discharge status of the beneficiary.
- (e) The hospital's Medicare provider number.
- (f) The source of the admission.

k. Prescription drugs and medicines (and insulin). For prescription drugs and medicines (and insulin, whether or not a prescription is required) receipted bills must be attached and the following additional information provided:

(1) Name of drug.

NOTE: When the physician or pharmacist so requests, the name of the drug may be submitted to the CHAMPUS fiscal intermediary directly by the physician or pharmacist.

(2) Strength of drug.

(3) Name and address of pharmacy where drug was purchased.

(4) Prescription number of drug being claimed.

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1. Other authorized providers. For items from other authorized providers (such as medical supplies), an explanation as to the medical need must be attached to the appropriate claim form. For purchases of durable equipment under the PFTH, it is necessary also to attach a copy of the pre-authorization.

m. Nonparticipating providers. When the beneficiary or sponsor submits the claim to the CHAMPUS fiscal intermediary (that is, the provider elects not to participate), an itemized bill from the provider to the beneficiary or sponsor must be attached to the CHAMPUS claim form.

4. Double coverage information. When the CHAMPUS beneficiary is eligible for medical benefits coverage through another plan, insurance, or program, either private or Government, the following information must be provided:

a. Name of other coverage. Full name and address of double coverage plan, insurance, or program (such as Blue Cross, Medicare, commercial insurance, and state program).

b. Source of double coverage. Source of double coverage (such as employment, including retirement, private purchase, membership in a group, and law).

c. Employer information. If source of double coverage is employment, give name and address of employer.

d. Identification number. Identification number or group number of other coverage.

5. Right to additional information

a. As a condition precedent to the provision of benefits under this Regulation, OCHAMPUS or CHAMPUS fiscal intermediaries may request and shall be entitled to receive information from a physician or hospital or other person, institution, or organization (including a local, state, or Federal Government agency) providing services or supplies to the beneficiary for whom claims or requests for approval for benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, examination, diagnosis, treatment, or services and supplies furnished to a beneficiary and as shall be necessary for the accurate and efficient administration of CHAMPUS benefits. In addition, before a determination on a request for preauthorization or claim of benefits is made, a beneficiary, or sponsor, shall provide additional information relevant to the requested determination, when necessary. The recipient of such information shall hold such records confidential except when:

(1) Disclosure of such information is authorized specifically by the beneficiary;

(2) Disclosure is necessary to permit authorized governmental officials to investigate and prosecute criminal actions; or

(3) Disclosure is authorized or required specifically under the terms of DoD Directives 5400.7 and 5400.11, the Freedom of Information Act, and the Privacy Act (references (i), (j), and (k)) (refer to section M. of Chapter 1 of this Regulation).

b. For the purposes of determining the applicability of and implementing the provisions of Chapters 8 and 9, or any provision of similar purpose of any other medical benefits coverage or entitlement, OCHAMPUS or CHAMPUS fiscal intermediaries, without consent or notice to any beneficiary or sponsor, may release to or obtain from any insurance company or other organization, governmental agency, provider, or person, any information with respect to any beneficiary when such release constitutes a routine use duly published in the Federal Register in accordance with the Privacy Act (reference (k)). Before a beneficiary's claim of benefits will be adjudicated, the beneficiary must furnish to CHAMPUS that information which reasonably may be expected to be in his or her possession and which is necessary to make the benefit determination. Failure to provide the requested information may result in denial of the claim.

C. SIGNATURE ON CHAMPUS CLAIM FORM

1. Beneficiary signature. CHAMPUS claim forms must be signed by the beneficiary except under the conditions identified in paragraph C.1.e., below. The parent or guardian may sign for any beneficiary under 18 years.

a. Certification of identity. This signature certifies that the patient identification information provided is correct.

b. Certification of medical care provided. This signature certifies that the specific medical care for which benefits are being claimed actually were rendered to the beneficiary on the dates indicated.

c. Authorization to obtain or release information. Before requesting additional information necessary to process a claim or releasing medical information, the signature of the beneficiary who is 18 years old or older must be recorded on or obtained on the CHAMPUS claim form or on a separate release form. The signature of the beneficiary, parent, or guardian will be requested when the beneficiary is under 18 years.

d. Certification of accuracy and authorization to release double coverage information. This signature certifies to the accuracy of the double coverage information and authorizes the release of any information related to double coverage. (Refer to Chapter 8 of this Regulation.)

e. Exceptions to beneficiary signature requirement

(1) Except as required by paragraph C.1.c., above, the signature of a spouse, parent, or guardian will be accepted on a claim submitted for a beneficiary who is 18 years old or older.

(2) When the institutional provider obtains the signature of the beneficiary (or the signature of the parent or guardian when the beneficiary is under 18 years) on a CHAMPUS claim form at admission, the following participating claims may be submitted without the beneficiary's signature.

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(a) Claims for laboratory and diagnostic tests and test interpretations from radiologists, pathologists, neurologists, and cardiologists.

(b) Claims from anesthesiologists.

(3) Claims filed by providers using CHAMPUS-approved signature-on-file and claims submission procedures.

2. Provider's signature. A participating provider (see subsection A.8. of Chapter 6) is required to sign the CHAMPUS claim form.

a. Certification. A participating provider's signature on a CHAMPUS claim form:

(1) Certifies that the specific medical care listed on the claim form was, in fact, rendered to the specific beneficiary for which benefits are being claimed on the specific date or dates indicated.

(2) Certifies that the provider has agreed to participate (providing this agreement has been indicated on the claim form) and that the CHAMPUS-determined allowable charge or cost will constitute the full charge or cost for the medical care listed on the specific claim form; and further agrees to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-shared amount paid by, or on behalf of the beneficiary, as full payment for the covered medical services or supplies.

(a) Thus, neither CHAMPUS nor the sponsor is responsible for any additional charges, whether or not the CHAMPUS-determined charge or cost is less than the billed amount.

(b) Any provider who signs and submits a CHAMPUS claim form and then violates this agreement by billing the beneficiary or sponsor for any difference between the CHAMPUS-determined charge or cost and the amount billed is acting in bad faith and is subject to penalties including withdrawal of CHAMPUS approval as a CHAMPUS provider by administrative action of the Director, OCHAMPUS, or a designee, and possible legal action on the part of CHAMPUS, either directly or as a part of a beneficiary action, to recover monies improperly obtained from CHAMPUS beneficiaries or sponsors (refer to Chapter 6 of this Regulation).

b. Physician or other authorized individual professional provider. A physician or other authorized individual professional provider is liable for any signature submitted on his or her behalf. Further, a facsimile signature is not acceptable unless such facsimile signature is on file with, and has been authorized specifically by, the CHAMPUS fiscal intermediary serving the state where the physician or other authorized individual professional provider practices.

c. Hospital or other authorized institutional provider. The provider signature on a claim form for institutional services must be that of an authorized representative of the hospital or other authorized institutional provider, whose signature is on file with and approved by the appropriate CHAMPUS fiscal intermediary.

D. CLAIMS FILING DEADLINE

To be considered for benefits, all claims submitted under CHAMPUS must be filed with the appropriate CHAMPUS fiscal intermediary no later than December 31 of the calendar year immediately following the one in which the covered service or supply was rendered. Failure to file a claim timely waives automatically all rights to any benefits for such services or supplies provided during the period affected by the claims filing deadline.

1. Claims returned for additional information. When a claim initially is submitted within the claims filing time limit, but is returned in whole or in part for additional information to be considered for benefits, the returned claim, along with the requested information, must be resubmitted and received by the appropriate CHAMPUS fiscal intermediary no later than the applicable December 31 deadline or 90 days from the date the claim was returned to the beneficiary, whichever is later.

2. Exception to claims filing deadline. The Director, OCHAMPUS, or a designee, may grant exceptions to the claims filing deadline requirements.

a. Types of exception

(1) Retroactive eligibility. Retroactive CHAMPUS eligibility determinations.

(2) Administrative error. Administrative error (that is, misrepresentation, mistake, or other accountable action) of an officer or employee of OCHAMPUS (including OCHAMPUSEUR) or a CHAMPUS fiscal intermediary, performing functions under CHAMPUS and acting within the scope of that official's authority.

(3) Mental incompetency. Mental incompetency of the beneficiary or guardian or sponsor, in the case of a minor child (which includes inability to communicate, even if it is the result of a physical disability).

(4) Provider billings. Direct billings by participating providers.

(5) Delays by other health insurance. When not attributable to the beneficiary, delays in adjudication by other health insurance companies when double coverage coordination is required before the CHAMPUS benefit determination.

b. Request for exception to claims filing deadline. Beneficiaries who wish to request an exception to the claims filing deadline may submit such a request to the CHAMPUS fiscal intermediary having jurisdiction over the location in which the service was rendered, or as otherwise designated by the Director, OCHAMPUS.

(1) Such requests for an exception must include a complete explanation of the circumstances of the late filing, together with all available documentation supporting the request, and the specific claim denied for late filing.

(2) Each request for an exception to the claims filing deadline is reviewed individually and considered on its own merits.

E. OTHER CLAIMS FILING REQUIREMENTS

Notwithstanding the claims filing deadline described in section D. of this chapter, to lessen any potential adverse impact on a CHAMPUS beneficiary or sponsor that could result from a retroactive denial, the following additional claims filing procedures are recommended or required.

1. Continuing care. Except for claims subject to the CHAMPUS DRG-based payment system, whenever medical services and supplies are being rendered on a continuing basis, an appropriate claim or claims should be submitted every 30 days (monthly) whether submitted directly by the beneficiary or sponsor or by the provider on behalf of the beneficiary. Such claims may be submitted more frequently if the beneficiary or provider so elects. The Director, OCHAMPUS, or a designee, also may require more frequent claims submission based on dollars. Examples of care that may be rendered on a continuing basis are outpatient physical therapy, private duty (special) nursing, or inpatient stays. For claims subject to the CHAMPUS DRG-based payment system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

2. Inpatient mental health services. Under most circumstances, the 60-day inpatient mental health limit applies to the first 60 days of care paid in a calendar year. The patient will be notified when the first 30 days of inpatient mental health benefits have been paid. The beneficiary is responsible for assuring that all claims for care are submitted sequentially and on a regular basis. Once payment has been made for care determined to be medically appropriate and a program benefit, the decision will not be reopened solely on the basis that previous inpatient mental health care had been rendered but not yet billed during the same calendar year by a different provider.

3. Claims involving the services of marriage and family counselors, pastoral counselors, and mental health counselors. CHAMPUS requires that marriage and family counselors, pastoral counselors, and mental health counselors make a written report to the referring physician concerning the CHAMPUS beneficiary's progress. Therefore, each claim for reimbursement for services of marriage and family counselors, pastoral counselors, and mental health counselors must include certification to the effect that a written communication has been made or will be made to the referring physician at the end of treatment, or more frequently, as required by the referring physician.

F. PREAUTHORIZATION

When specifically required in other chapters of this Regulation, preauthorization requires the following:

1. Preauthorization must be granted before benefits can be extended. In those situations requiring preauthorization, the request for such pre-

authorization shall be submitted and approved before benefits may be extended, except as provided in Chapter 4, subsection A.11. If a claim for services or supplies is submitted without the required preauthorization, no benefits shall be paid, unless the Director, OCHAMPUS, or a designee, has granted an exception to the requirement for preauthorization.

a. Specifically preauthorized services. An approved preauthorization specifies the exact services or supplies for which authorization is being given. In a preauthorization situation, benefits cannot be extended for services or supplies provided beyond the specific authorization.

b. Time limit on preauthorization. Approved preauthorizations are valid for specific periods of time, usually 90 days. If the preauthorized services or supplies are not obtained or commenced within the specified time limit, a new preauthorization is required before benefits may be extended.

2. Treatment plan, management plan. Each preauthorization request shall be accompanied by a proposed medical treatment plan (for inpatient stays under the Basic Program) or management plan (for services under the PFTH) which shall include generally a diagnosis; a detailed summary of complete history and physical; a detailed statement of the problem; the proposed type and extent of treatment or therapy; the proposed treatment modality, including anticipated length of time the proposed modality will be required; any available test results; consultant's reports; and the prognosis. When the preauthorization request involves transfer from a hospital to another inpatient facility, medical records related to the inpatient stay also must be provided.

3. Durable equipment. Requests for preauthorization to purchase durable equipment under the PFTH must list all items of durable equipment previously authorized under the PFTH and state whether the current item of equipment is the initial purchase or a replacement. If it is a replacement item, the date the initial item was purchased also shall be provided.

4. Claims for services and supplies that have been preauthorized. Whenever a claim is submitted for benefits under CHAMPUS involving preauthorized services and supplies, the date of the approved preauthorization must be indicated on the claim form and a copy of the written preauthorization must be attached to the appropriate CHAMPUS claim.

G. CLAIMS REVIEW

It is the responsibility of the CHAMPUS fiscal intermediary (or OCHAMPUS, including OCHAMPUSEUR) to review each CHAMPUS claim submitted for benefit consideration to ensure compliance with all applicable definitions, conditions, limitations, or exclusions specified or enumerated in this Regulation. It is also required that before any CHAMPUS benefits may be extended, claims for medical services and supplies will be subject to utilization review and quality assurance standards, norms, and criteria issued by the Director, OCHAMPUS, or a designee (see paragraph A.1.e. of Chapter 14 for review standards for claims subject to the CHAMPUS DRG-based payment system).

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H. BENEFIT PAYMENTS

CHAMPUS benefit payments are made either directly to the beneficiary or sponsor or to the provider, depending on the manner in which the CHAMPUS claim is submitted.

1. Benefit payments made to beneficiary or sponsor. When the CHAMPUS beneficiary or sponsor signs and submits a specific claim form directly to the appropriate CHAMPUS fiscal intermediary (or OCHAMPUS, including OCHAMPUSEUR), any CHAMPUS benefit payments due as a result of that specific claim submission will be made in the name of, and mailed to, the beneficiary or sponsor. In such circumstances, the beneficiary or sponsor is responsible to the provider for any amounts billed.

2. Benefit payments made to participating provider. When the authorized provider elects to participate by signing a CHAMPUS claim form, indicating participation in the appropriate space on the claim form, and submitting a specific claim on behalf of the beneficiary to the appropriate CHAMPUS fiscal intermediary, any CHAMPUS benefit payments due as a result of that claim submission will be made in the name of and mailed to the participating provider. Thus, by signing the claim form, the authorized provider agrees to abide by the CHAMPUS-determined allowable charge or cost, whether or not lower than the amount billed. Therefore, the beneficiary or sponsor is responsible only for any required deductible amount and any cost-sharing portion of the CHAMPUS-determined allowable charge or cost as may be required under the terms and conditions set forth in Chapters 4 and 5 of this Regulation.

3. CEOB. When a CHAMPUS claim is adjudicated, a CEOB is sent to the beneficiary or sponsor. A copy of the CEOB also is sent to the provider if the claim was submitted on a participating basis. The CEOB form provides, at a minimum, the following information:

- a. Name and address of beneficiary.
- b. Name and address of provider.
- c. Services or supplies covered by claim for which CEOB applies.
- d. Dates services or supplies provided.
- e. Amount billed; CHAMPUS-determined allowable charge or cost; and amount of CHAMPUS payment.
- f. To whom payment, if any, was made.
- g. Reasons for any denial.
- h. Recourse available to beneficiary for review of claim decision (refer to Chapter 10 of this Regulation).

NOTE: The Director, OCHAMPUS, or a designee, may authorize a CHAMPUS fiscal intermediary to waive a CEOB to protect the privacy of a CHAMPUS beneficiary

4. Benefit under \$1. If the CHAMPUS benefit is determined to be under \$1, payment is waived.

I. ERRONEOUS PAYMENTS AND RECOUPMENT

1. Erroneous payments. Erroneous payments are expenditures of government funds that are not authorized by law or the Regulation. Such payments are to be recouped under the provisions of Chapter 11 of this Regulation.

2. Claims denials resulting from clarification or change in law or Regulation. In those instances where claims review results in a finding of denial of benefits previously allowed but currently denied due to a clarification or interpretation of law or this Regulation, or due to a change in this Regulation, no recoupment action need be taken to recover funds expended prior to the effective date of such clarification, interpretation, or change.

J. GENERAL ASSIGNMENT OF BENEFITS NOT RECOGNIZED

CHAMPUS does not recognize any general assignment of CHAMPUS benefits to another person. All CHAMPUS benefits are payable as described in this and other chapters of this Regulation.

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CHAPTER 8

DOUBLE COVERAGE

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CHAPTER 8
DOUBLE COVERAGE

A. INTRODUCTION

In enacting CHAMPUS legislation, Congress clearly has intended that CHAMPUS be the secondary payer to all health benefit and insurance plans. 10 U.S.C. 1079(j)(1) (reference (a)) specifically provides:

"A benefit may not be paid under a plan [CHAMPUS] covered by this section in the case of a person enrolled in any other insurance, medical service, or health plan to the extent that the benefit also is a benefit under other plans, except in the case of a plan [Medicaid] administered under title 19 of the Social Security Act (42 U.S.C. 1306 et seq.)."

The above provision is made applicable specifically to retired members, dependents, and survivors by 10 U.S.C. 1086(d) reference (a)). The underlying intent, in addition to preventing waste of Federal resources, is to ensure that CHAMPUS beneficiaries receive maximum benefits while ensuring that the combined payments of CHAMPUS and other health benefit and insurance plans do not exceed the total charges.

B. DOUBLE COVERAGE PLAN

A double coverage plan is one of the following:

1. Insurance plan. An insurance plan is any plan or program that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services and supplies. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled as a result of employment or membership in, or association with, an organization or group.

2. Medical service or health plan. A medical service or health plan is any plan or program of an organized health care group, corporation, or other entity for the provision of health care to an individual from plan providers, both professional and institutional. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled as a result of employment or membership in, or association with, an organization or group.

3. Exceptions. Double coverage plans do not include:

a. Plans administered under title XIX of the Social Security Act (Medicaid) (reference (h));

b. Coverage specifically designed to supplement CHAMPUS benefits;

c. Entitlement to receive care from Uniformed Services medical care facilities; or

d. Certain Federal Government programs, as prescribed by the Director, OCHAMPUS, that are designed to provide benefits to a distinct beneficiary population and for which entitlement does not derive from either premium payment of monetary contribution (for example, the Indian Health Service).

C. APPLICATION OF DOUBLE COVERAGE PROVISIONS

CHAMPUS claims submitted for otherwise covered services or supplies and which involve double coverage shall be adjudicated as follows:

1. CHAMPUS always last pay. For any claim that involves a double coverage plan as defined above, CHAMPUS shall be last pay. That is, CHAMPUS benefits may not be extended until all other double coverage plans have adjudicated the claim.

2. Waiver of benefits. A CHAMPUS beneficiary may not elect to waive benefits under a double coverage plan and use CHAMPUS. Whenever double coverage exists, the provisions of this chapter shall be applied.

3. Last pay limitations. CHAMPUS may not pay more as a secondary payer than it would have in the absence of other coverages. Application of double coverage provisions does not extend or add to the CHAMPUS benefits as otherwise set forth in this and other chapters of this Regulation.

D. SPECIAL CONSIDERATIONS

1. CHAMPUS and Medicare. In any double coverage situation involving Medicare, Medicare is always the primary payer. When Part A, "Hospital Insurance," of Medicare is involved, the Medicare "lifetime reserve" benefit must be used before CHAMPUS benefits may be extended.

2. CHAMPUS and Medicaid. Medicaid is not a double coverage plan. In any double coverage situation involving Medicaid, CHAMPUS is always the primary payer.

3. CHAMPUS and Worker's Compensation. CHAMPUS benefits are not payable for a work-related illness or injury that is covered under a worker's compensation program.

4. PFTH. All local resources must be considered and used before CHAMPUS benefits under the PFTH may be extended. If a handicapped CHAMPUS beneficiary who otherwise is eligible for benefits under the PFTH is eligible for other Federal, state, or local assistance to the same extent as any other resident or citizen, CHAMPUS benefits are not payable. The sponsor does not have the option of waiving available Federal, state, or local assistance in favor of using CHAMPUS benefits.

E. IMPLEMENTING INSTRUCTIONS

The Director, OCHAMPUS, or a designee, shall issue such instructions, procedures, or guidelines, as necessary, to implement the intent of this chapter.

CHAPTER 9

ADMINISTRATIVE REMEDIES FOR FRAUD, ABUSE, AND CONFLICT OF INTEREST

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CHAPTER 9
ADMINISTRATIVE REMEDIES FOR FRAUD, ABUSE, AND CONFLICT OF INTEREST

A. GENERAL

1. This chapter sets forth provisions for invoking administrative remedies under CHAMPUS in situations involving fraud, abuse, or conflict of interest. The remedies impact institutional providers, professional providers, and beneficiaries (including parents, guardians, or other representatives of beneficiaries), and cover situations involving criminal fraud, civil fraud, administrative determinations of conflicts of interest or dual compensation, and administrative determinations of fraud or abuse. The administrative actions, remedies, and procedures may differ based upon whether the initial findings were made by a court of law, another agency, or the Director, OCHAMPUS (or designee).

2. This chapter also sets forth provisions for invoking administrative remedies in situations requiring administrative action to enforce provisions of law, regulation, and policy in the administration of CHAMPUS and to ensure quality of care for CHAMPUS beneficiaries. Examples of such situations may include a case in which it is discovered that a provider fails to meet requirements under this Regulation to be an authorized CHAMPUS provider; a case in which the provider ceases to be qualified as a CHAMPUS provider because of suspension or revocation of the provider's license by a local licensing authority; or a case in which a provider meets the minimum requirements under this Regulation but, nonetheless, it is determined that it is in the best interest of the CHAMPUS or CHAMPUS beneficiaries that the provider should not be an authorized CHAMPUS provider.

3. The administrative remedies set forth in this chapter are in addition to, and not in lieu of, any other remedies or sanctions authorized by law or regulation. For example, administrative action under this chapter may be taken in a particular case even if the same case will be or has been processed under the administrative procedures established by the Department of Defense to implement the Program Fraud Civil Remedies Act.

4. Providers seeking payment from the Federal Government through programs such as CHAMPUS have a duty to familiarize themselves with, and comply with, the program requirements.

5. CHAMPUS contractors and peer review organizations have a responsibility to apply provisions of this regulation in the discharge of their duties, and to report all known situations involving fraud, abuse, or conflict of interest. Failure to report known situations involving fraud, abuse, or conflict of interest will result in the withholding of administrative payments or other contractual remedies as determined by the Director, OCHAMPUS, or a designee.

B. ABUSE

The term "abuse" generally describes incidents and practices which may directly or indirectly cause financial loss to the Government under CHAMPUS

or to CHAMPUS beneficiaries. For the definition of abuse, see Chapter 2 of this Regulation. The type of abuse to which CHAMPUS is most vulnerable is the CHAMPUS claim involving the overutilization of medical and health care services. To avoid abuse situations, providers have certain obligations to provide services and supplies under CHAMPUS which are: (i) furnished at the appropriate level and only when and to the extent medically necessary as determined under the provisions of this Regulation; (ii) of a quality that meets professionally recognized standards of health care; and, (iii) supported by adequate medical documentation as may reasonably be required under this Regulation by the Director, OCHAMPUS, or a designee, to evidence the medical necessity and quality of services furnished, as well as the appropriateness of the level of care. A provider's failure to comply with these obligations can result in sanctions being imposed by the Director, OCHAMPUS, or a designee, under this chapter. Even when administrative remedies are not initiated under this chapter, abuse situations under CHAMPUS are a sufficient basis for denying all or any part of CHAMPUS cost-sharing of individual claims. The types of abuse or possible abuse situations under CHAMPUS include, but are not limited, to the following:

1. A pattern of waiver of beneficiary (patient) cost-share or deductible.

NOTE: In a case of a legitimate bad debt write-off of patient cost-share or deductible, the provider's record should include documentation as to what efforts were made to collect the debt, when the debt was written off, why the debt was written off, and the amount of the debt written off.

2. Improper billing practices. Examples include, charging CHAMPUS beneficiaries rates for services and supplies that are in excess of those charges routinely charged by the provider to the general public, commercial health insurance carriers, or other federal health benefit entitlement programs for the same or similar services. (This includes dual fee schedules - one for CHAMPUS beneficiaries and one for other patients or third party payers. This also includes billing other third-party payers the same as CHAMPUS is billed but accepting less than the billed amount as reimbursement. However, a formal discount arrangement such as through a preferred provider organization, may not necessarily constitute an improper billing practice.)

3. A pattern of claims for services which are not medically necessary or, if medically necessary, not to the extent rendered. For example, a battery of diagnostic tests are given when, based on the diagnosis, fewer tests were needed.

4. Care of inferior quality. For example, consistently furnishing medical or mental health services that do not meet accepted standards of care.

5. Failure to maintain adequate medical or financial records.

6. Refusal to furnish or allow the Government (for example, OCHAMPUS) or Government contractors access to records related to CHAMPUS claims.

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7. Billing substantially in excess of customary or reasonable charges unless it is determined by OCHAMPUS that the excess charges are justified by unusual circumstances or medical complications requiring additional time, effort, or expense in localities when it is accepted medical practice to make an extra charge in such cases.

8. Unauthorized use of the term "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)" in private business. While the use of the term "CHAMPUS" is not prohibited by federal statute, misrepresentation or deception by use of the term "CHAMPUS" to imply an official connection with the Government or to defraud CHAMPUS beneficiaries may be a violation of federal statute. Regardless of whether the actual use of the term "CHAMPUS" may be actionable under federal statute, the unauthorized or deceptive use of the term "CHAMPUS" in private business will be considered abuse for purposes of this chapter.

C. FRAUD

For the definition of fraud, see Chapter 2 of this Regulation. Examples of situations which, for the purpose of this Regulation, are presumed to be fraud include, but are not limited to:

1. Submitting CHAMPUS claims (including billings by providers when the claim is submitted by the beneficiary) for services, supplies, or equipment not furnished to, or used by, CHAMPUS beneficiaries. For example, billing or claiming services when the provider was on call (other than an authorized standby charge) and did not provide any specific medical care to the beneficiary; providing services to an ineligible person and billing or submitting a claim for the services in the name of an eligible CHAMPUS beneficiary; billing or submitting a CHAMPUS claim for an office visit for a missed appointment; or billing or submitting a CHAMPUS claim for individual psychotherapy when a medical visit was the only service provided.

2. Billing or submitting a CHAMPUS claim for costs for noncovered or nonchargeable services, supplies, or equipment disguised as covered items. Some examples are: (i) billings or CHAMPUS claims for services which would be covered except for the frequency or duration of the services, such as billing or submitting a claim for two one-hour psychotherapy sessions furnished on separate days when the actual service furnished was a two-hour therapy session on a single day, (ii) spreading the billing or claims for services over a time period that reduces the apparent frequency to a level that may be cost-shared by CHAMPUS, (iii) charging to CHAMPUS, directly or indirectly, costs not incurred or not reasonably allowable to the services billed or claimed under CHAMPUS, for example, costs attributable to nonprogram activities, other enterprises, or the personal expenses of principals, or (iv) billing or submitting claim on a fee-for-service basis when in fact a personal service to a specific patient was not performed and the service rendered is part of the overall management of, for example, the laboratory or x-ray department.

3. Breach of a provider participation agreement which results in the beneficiary (including parent, guardian, or other representative) being billed for amounts which exceed the CHAMPUS-determined allowable charge or cost.

4. Billings or CHAMPUS claims for supplies or equipment which are clearly unsuitable for the patient's needs or are so lacking in quality or sufficiency for the purpose as to be virtually worthless.

5. Billings or CHAMPUS claims which involve flagrant and persistent overutilization of services without proper regard for results, the patient's ailments, condition, medical needs, or the physician's orders.

6. Misrepresentations of dates, frequency, duration, or description of services rendered, or of the identity of the recipient of the services or the individual who rendered the services.

7. Submitting falsified or altered CHAMPUS claims or medical or mental health patient records which misrepresent the type, frequency, or duration of services or supplies or misrepresent the name(s) of the individual(s) who provided the services or supplies.

8. Duplicate billings or CHAMPUS claims. This includes billing or submitting CHAMPUS claims more than once for the same services, billing or submitting claims both to CHAMPUS and the beneficiary for the same services, or billing or submitting claims both to CHAMPUS and other third-parties (such as other health insurance or government agencies) for the same services, without making full disclosure of material facts or immediate, voluntary repayment or notification to CHAMPUS upon receipt of payments which combined exceed the CHAMPUS-determined allowable charge of the services involved.

9. Misrepresentation by a provider of his or her credentials or concealing information or business practices which bear on the provider's qualifications for authorized CHAMPUS provider status. For example, a provider representing that he or she has a qualifying doctorate in clinical psychology when the degree is not from a regionally accredited university.

10. Reciprocal billing. Billing or claiming services which were furnished by another provider or furnished by the billing provider in a capacity other than as billed or claimed. For example, practices such as the following: (i) one provider performing services for another provider and the latter bills as though he had actually performed the services (e.g., a weekend fill-in); (ii) providing service as an institutional employee and billing as a professional provider for the services; (iii) billing for professional services when the services were provided by another individual who was an institutional employee; (iv) billing for professional services at a higher provider profile than would be paid for the person actually furnishing the services, (for example, bills reflecting that an M.D. or Ph.D. performed the services when services were actually furnished by a licensed social worker, psychiatric nurse, or marriage and family counselor); or (v) an authorized provider billing for services which were actually furnished by an unauthorized or sanctioned provider.

11. Submitting CHAMPUS claims at a rate higher than a rate established between CHAMPUS and the provider, if such a rate has been established. For example, billing or claiming a rate in excess of the provider's most favored rate limitation specified in a residential treatment center agreement.

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12. Arrangements by providers with employees, independent contractors, suppliers, or others which appear to be designed primarily to overcharge the CHAMPUS through various means (such as commissions, fee-splitting, and kickbacks) used to divert or conceal improper or unnecessary costs or profits.

13. Agreements or arrangements between the supplier and recipient (recipient could be either a provider or beneficiary, including the parent, guardian, or other representative of the beneficiary) that result in billings or claims which include unnecessary costs or charges to CHAMPUS.

D. CONFLICT OF INTEREST

1. Conflict of interest includes any situation where an active duty member of the Uniformed Services (including a reserve member while on active duty, active duty for training, or inactive duty training) or civilian employee of the United States Government, through an official federal position has the apparent or actual opportunity to exert, directly or indirectly, any influence on the referral of CHAMPUS beneficiaries to himself/herself or others with some potential for personal gain or the appearance of impropriety. Although individuals under contract to the Uniformed Services are not considered "employees," such individuals are subject to conflict of interest provisions by express terms of their contracts and, for purposes of this Regulation, may be considered to be involved in conflict of interest situations as a result of their contract positions. In any situation involving potential conflict of interest of a Uniformed Service employee, the Director, OCHAMPUS, or a designee, may refer the case to the Uniformed Service concerned for appropriate review and action. If such a referral is made, a report of the results of findings and action taken shall be made to the Director, OCHAMPUS, by the Uniformed Service having jurisdiction within 90 days of receiving the referral.

2. CHAMPUS cost-sharing shall be denied on any claim where a conflict of interest situation is found to exist. This denial of cost-sharing applies whether the claim is submitted by the individual who provided the care, the institutional provider in which the care was furnished, or the beneficiary.

E. DUAL COMPENSATION

1. Federal law (5 U.S.C. 5536) prohibits active duty members of the Uniformed Services or employees (including part-time or intermittent) appointed in the civil service of the United States Government from receiving additional compensation from the Government above their normal pay and allowances. This prohibition applies to CHAMPUS payments for care furnished to CHAMPUS beneficiaries by active duty members of the Uniformed Services or civilian employees of the Government.

2. CHAMPUS cost-sharing of a claim shall be denied where the services or supplies were provided by an active duty member of the Uniformed Services or a civilian employee of the Government. This denial of CHAMPUS payment applies whether the claim for reimbursement is filed by the individual who provided the care, the institutional provider in which the care was furnished, or by the beneficiary.

NOTE: Physicians of the National Health Service Corps (NHSC) may be assigned to areas where there is a shortage of medical providers. Although these physicians would be prohibited from accepting CHAMPUS payments as individuals if they are employees of the United States Government, the private organizations to which they may be assigned may be eligible for payment, as determined by the Director, OCHAMPUS, or a designee.

3. The prohibition against dual compensation does not apply to individuals under contract to the Uniformed Services or the Government.

F. ADMINISTRATIVE REMEDIES

Administrative remedies available under CHAMPUS in this chapter are set forth below.

1. Provider exclusion or suspension. The Director, OCHAMPUS, or a designee, shall have the authority to exclude or suspend an otherwise authorized CHAMPUS provider from the program based on any criminal conviction or civil judgment involving fraud by the provider; fraud or abuse under CHAMPUS by the provider; exclusion or suspension of the provider by another agency of the Federal Government, a state, or local licensing authority; participation in a conflict of interest situation by the provider; or, when it is in the best interests of the program or CHAMPUS beneficiaries to exclude or suspend a provider under CHAMPUS. In all cases, the exclusion or suspension of a provider shall be effective 15 calendar days from the date on the written initial determination issued under subsection H.2. of this chapter.

a. Criminal conviction or civil judgment involving fraud by a provider.

(1) Criminal conviction involving CHAMPUS fraud. A provider convicted by a Federal, state, foreign, or other court of competent jurisdiction of a crime involving CHAMPUS fraud, whether the crime is a felony or misdemeanor, shall be excluded or suspended from CHAMPUS for a period of time as determined by the Director, OCHAMPUS, or a designee. The CHAMPUS exclusion or suspension applies whether or not the provider, as a result of the conviction, receives probation or the sentence is suspended or deferred, and whether or not the conviction or sentence is under appeal.

NOTE: Under the above paragraph a.(1), an entity may be excluded or suspended from CHAMPUS whenever the entity is found to have a person, convicted of a crime involving CHAMPUS fraud, who has a direct or indirect ownership or control interest (see Chapter 2) of 5 percent or more in the entity, or is an officer, director, agent or managing employee of the entity. The entity will have an opportunity to provide evidence to show that the ownership or control relationship has ceased. While an entity will not be excluded or suspended from CHAMPUS for employing a provider who has been sanctioned under this chapter, the entity will be denied CHAMPUS payment for any services furnished by the sanctioned employee. As an authorized CHAMPUS provider,

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the entity is responsible for ensuring that all CHAMPUS claims involve services furnished to CHAMPUS beneficiaries by employees who meet all requirements under CHAMPUS for provider status.

(2) Criminal conviction involving fraud of other Federal programs. Any provider convicted by a Federal, state, or other court of competent jurisdiction of a crime involving another Federal health care or benefit program (such as plans administered under titles XVIII and XIX of the Social Security Act, Federal Workmen's Compensation, and the Federal Employees Program (FEP) for employee health insurance), whether the crime is a felony or misdemeanor, shall be excluded from CHAMPUS for a period of time as determined by the Director, OCHAMPUS, or a designee. The CHAMPUS exclusion or suspension applies whether or not the provider, as a result of the conviction, receives probation or the sentence is suspended or deferred, and whether or not the conviction or sentence is under appeal.

(3) Criminal conviction involving fraud of non-Federal programs. Any provider convicted by a Federal, state, foreign, or other court of competent jurisdiction of a crime involving any non-Federal health benefit program or private insurance involving health benefits may be excluded or suspended from CHAMPUS for a period of time as determined by the Director, OCHAMPUS, or a designee.

(4) Civil fraud involving CHAMPUS. If a judgment involving civil fraud has been entered (whether or not it is appealed) against a provider in a civil action involving CHAMPUS benefits (whether or not other Federal programs are involved), the provider shall be excluded or suspended from CHAMPUS for a period determined by the Director, OCHAMPUS, or a designee.

(5) Civil fraud involving other programs. If a judgment involving civil fraud has been entered against a provider (whether or not it has been appealed) in a civil action involving other public or private health care programs or health insurance, the provider may be excluded or suspended for a period of time determined by the Director, OCHAMPUS, or a designee.

b. Administrative determination of fraud or abuse under CHAMPUS. If the Director, OCHAMPUS, or a designee, determines that a provider has committed fraud or abuse as defined in this Regulation, the provider shall be excluded or suspended from CHAMPUS for a period of time determined by the Director, OCHAMPUS, or designee.

c. Administrative determination that the provider has been excluded or suspended by another agency of the Federal Government, a state, or local licensing authority. Any provider who is excluded or suspended by any other Federal health care program (for example, Medicare), shall be excluded or suspended under CHAMPUS. A provider who has his/her credentials revoked through a Veterans Administration or Military Department credentials review process and who is excluded, suspended, terminated, retired, or separated, shall also be excluded or suspended under CHAMPUS. The period of time of exclusion or suspension shall be determined by the Director, OCHAMPUS, or a designee, pursuant to section G. of this chapter.

d. Administrative determination that the provider has participated in a conflict of interest situation. The Director, OCHAMPUS, or a designee, may exclude or suspend any provider who has knowingly been involved in a conflict of interest situation under CHAMPUS. The period of time of exclusion or suspension shall be determined by the Director, OCHAMPUS, or a designee, pursuant to section G. of this chapter. For purposes of this administrative determination, it will be presumed that a CHAMPUS provider knowingly participated in a conflict of interest situation if the provider employs, in the treatment of a CHAMPUS beneficiary (resulting in a CHAMPUS claim), any medical personnel who are active duty members of the Uniformed Services or civilian employees of the Government. The burden of proof to rebut this presumption rests with the CHAMPUS provider. Two exceptions will be recognized to the presumption that a conflict of interest exists. First, indirect CHAMPUS payments may be made to private organizations to which physicians of the National Health Service Corps (NHSC) are assigned. Second, any off duty Government medical personnel employed in an emergency room of an acute care hospital will be presumed not to have had the opportunity to exert, directly or indirectly, any influence on the referral of CHAMPUS beneficiaries; therefore, CHAMPUS payments may be made to the employing hospital provided the medical care was not furnished directly by the off-duty Government medical personnel in violation of dual compensation provisions.

e. Administrative determination that it is in the best interests of the CHAMPUS or CHAMPUS beneficiaries to exclude or suspend a provider.

(1) Unethical or improper practices or unprofessional conduct.

(a) In most instances, unethical or improper practices or unprofessional conduct by a provider will be program abuse and subject the provider to exclusion or suspension for abuse. However, in some cases such practices and conduct may provide an independent basis for exclusion or suspension of the provider by the Director, OCHAMPUS, or a designee.

(b) Such exclusions or suspensions may be based on findings or recommendations of state licensure boards, boards of quality assurance, other regulatory agencies, state medical societies, peer review organizations, or other professional associations.

(2) In any other case in which the Director, OCHAMPUS (or designee), determines that exclusion or suspension of a provider is in the best interests of CHAMPUS or CHAMPUS beneficiaries. The Director, OCHAMPUS, or a designee, may exclude or suspend any provider if it is determined that the authorization of that particular provider under CHAMPUS poses an unreasonable potential for fraud, abuse, or professional misconduct. Any documented misconduct by the provider reflecting on the business or professional competence or integrity of the provider may be considered. Situations in which the Director, OCHAMPUS, or a designee, may take administrative action under this chapter to protect CHAMPUS or CHAMPUS beneficiaries include, but are not limited to, a case in which it is determined that a provider poses an unreasonable potential cost to the Government to monitor the provider for fraud or abuse and to avoid the issuance of erroneous payments; or that the provider poses an unreasonable potential harm to the financial or health status of CHAMPUS beneficiaries; or

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that the provider poses any other unreasonable threat to the interests of CHAMPUS or CHAMPUS beneficiaries. One example of such circumstances involves a provider who, for his/her entire practice or for most of his/her practice, provides or bills for treatment that is not a CHAMPUS benefit, resulting in CHAMPUS frequently and repeatedly denying claims as non-covered services. This may occur when a professional provider furnishes sex therapy (a therapy which may be recognized by the provider's licensing authority but which is excluded from CHAMPUS coverage) and repeatedly submits CHAMPUS claims for the services.

2. Provider termination. The Director, OCHAMPUS, or a designee, shall terminate the provider status of any provider determined not to meet the qualifications established by this Regulation to be an authorized CHAMPUS provider.

a. Effective date of termination. Except as provided in paragraph G.2.b. of this chapter, the termination shall be retroactive to the date on which the provider did not meet the requirements of this Regulation.

(1) The retroactive effective date of termination shall not be limited due to the passage of time, erroneous payment of claims, or any other events which may be cited as a basis for CHAMPUS recognition of the provider notwithstanding the fact that the provider does not meet program qualifications. Unless specific provision is made in this Regulation to "grandfather" or authorize a provider who does not otherwise meet the qualifications established by this Regulation, all unqualified providers shall be terminated.

(2) Any claims cost-shared or paid under CHAMPUS for services or supplies furnished by the provider on or after the effective date of termination, even when the effective date is retroactive, shall be deemed an erroneous payment unless specific exception is provided in this Regulation. All erroneous payments are subject to collection under Chapter 11 of this Regulation.

(3) If an institution is terminated as an authorized CHAMPUS provider, the institution shall immediately give written notice of the termination to any CHAMPUS beneficiary (or their parent, guardian, or other representative) admitted to, or receiving care at, the institution on or after the effective date of the termination. In addition, when an institution is terminated with an effective date of termination after the date of the initial determination terminating the provider, any beneficiary admitted to the institution prior to the effective date of termination (or their parent, guardian, or other representative) shall be notified by the Director, OCHAMPUS, or a designee, by certified mail of the termination, and that CHAMPUS cost-sharing of the beneficiary's care in the institution will cease as of the effective date of the termination. However, any beneficiary admitted to the institution prior to any grace period extended to the institution under subparagraph F.2.b.(1) of this chapter shall be advised that, if the beneficiary's care otherwise qualifies for CHAMPUS coverage, CHAMPUS cost-sharing of the care in the institution will continue in order to provide a reasonable period of transition of care; however the transitional period of CHAMPUS cost-sharing shall not exceed the last day of the month following the month in which the institution's status as a CHAMPUS provider

is terminated. (This authorized CHAMPUS cost-sharing of the inpatient care received during the transition period is an exception to the general rule that CHAMPUS payment for care furnished after the effective date of termination of the provider's status shall be deemed to be an erroneous payment.) If a major violation under subparagraph F.2.b.(1) of this chapter is involved, in order to ensure immediate action is taken to transfer beneficiaries to an approved provider, CHAMPUS cost-sharing shall not be authorized after the effective date of termination of the provider's status.

b. Institutions not in compliance with CHAMPUS standards. If it is determined that an institution is not in compliance with one or more of the standards applicable to its specific category of institution under this Regulation, the Director, OCHAMPUS, or a designee, shall take immediate steps to bring about compliance or terminate the status of the provider as an authorized CHAMPUS provider.

(1) Minor violations. An institution determined to be in violation of one or more of the standards shall be advised by certified mail of the nature of the discrepancy or discrepancies and will be given a grace period of 30 days to effect appropriate corrections. The grace period may be extended at the discretion of the Director, OCHAMPUS, or a designee, but in no event shall the extension exceed 90 days.

(a) CHAMPUS will not cost-share a claim for any beneficiary admitted during the grace period.

(b) Any beneficiary admitted to the institution prior to the grace period (or the beneficiary's parent, guardian, or other representative) will be notified by the Director, OCHAMPUS, or a designee, in writing, of the minor violations and the grace period granted the institution to correct the violations. The beneficiary will also be advised that, if the beneficiary's care otherwise meets all requirements for CHAMPUS coverage, CHAMPUS cost-sharing will continue during the grace period.

(c) If the institution submits written notice before the end of the grace period that corrective action has been taken and if the Director, OCHAMPUS, or a designee, determines that the corrective action has eliminated the minor violations, the provider will be advised that the institution is restored to full status as an authorized CHAMPUS provider as of 12:01 a.m. on the day written notice of correction was received by the Director, OCHAMPUS, or a designee, or the day on which acceptable corrective action was completed in the judgment of the Director, OCHAMPUS, or a designee. Any beneficiary admitted to the institution prior to the grace period will be notified by the Director, OCHAMPUS, or a designee, of the corrective action and that the provider continues to be an authorized CHAMPUS provider. CHAMPUS cost-sharing for any beneficiary admitted to the institution during the grace period shall be allowed only for care received after 12:01 a.m. on the day written notice of correction was received by the Director, OCHAMPUS, or a designee, or the day on which acceptable corrective action was completed in the judgment of the Director, OCHAMPUS, or a designee.

(d) If the institution has failed to give notification in

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writing before the end of the grace period that corrective action has been completed or, in the judgment of the Director, OCHAMPUS, or a designee, the institution has not completed acceptable corrective action during the grace period, the Director, OCHAMPUS, or a designee, may initiate action to terminate the provider as an authorized CHAMPUS provider.

(2) Major violations. If the Director, OCHAMPUS, or a designee, determines that an institution is in violation of standards detrimental to life, safety, or health, or substantially in violation of approved treatment programs, immediate action shall be taken to terminate the institution as an authorized CHAMPUS provider. The institution shall be notified by telegram, certified mail, or express mail of the termination under this subparagraph, effective on receipt of the notice. The notice shall include a brief statement of the nature of violations resulting in the termination and advise the institution that an initial determination formalizing the administrative action of termination will be issued pursuant to paragraph H.3.b. of this chapter within 15 days.

3. Beneficiary sanctions.

a. With entitlement to CHAMPUS benefits based on public law, an eligible beneficiary will not be suspended or excluded from CHAMPUS. However, the Director, OCHAMPUS, or a designee, may take action deemed appropriate and reasonable to protect the Government from those beneficiaries (including sponsors, parents, guardians, or representatives of beneficiaries) who have submitted false claims.

b. Pursuant to Chapter 11 of this Regulation, the Director, OCHAMPUS, or a designee, may recover erroneous payments on claims involving fraud or false or misleading statements. Remedies for recovery of the erroneous payments include the use of offset against future CHAMPUS payments.

c. Under policies adopted by the Director, OCHAMPUS, or a designee, individuals who, based on reliable information, have previously submitted fraudulent or false CHAMPUS claims, may be required to comply with any procedures (e.g., partial or total pre-payment audit or review, restriction to a designated primary care provider, etc.) which the Director, OCHAMPUS, or a designee, deems appropriate to ensure that their future medical care and CHAMPUS claims (including the medical care and CHAMPUS claims submitted by or for members of their family) are valid.

G. PERIOD OF EXCLUSION, SUSPENSION, OR TERMINATION

1. Exclusions or suspensions. Except as otherwise required by paragraph G.1.a. below, the Director, OCHAMPUS, or a designee, shall determine the period of exclusion or suspension for a provider using the factors set forth in paragraph G.1.b. of this section.

a. Exclusion or suspension of a provider based on the provider's exclusion or suspension by another agency of the Federal Government, a state, or a local licensing authority. If the administrative action under CHAMPUS is based solely on the provider's exclusion or suspension by another agency, state, or local licensing authority, the period of exclusion or suspension

under CHAMPUS shall be for the same length of time of exclusion or suspension imposed by the other agency, state, or local licensing authority. The provider may request reinstatement as an authorized CHAMPUS provider if reinstatement is achieved under the other program prior to the end of the period of exclusion or suspension. If the administrative action under CHAMPUS is not based solely on the provider's exclusion or suspension by another agency, state, or local licensing authority, the minimum period of exclusion or suspension shall be for the same period of exclusion or suspension imposed by the other agency, state, or local licensing authority.

b. Factors to be considered in determining the period of exclusion or suspension of providers under CHAMPUS. In determining the period of exclusion or suspension of a provider, the Director, OCHAMPUS, or a designee, may consider any or all of the following:

(1) When the case concerns all or any part of the same issues which have been the subject of criminal conviction or civil judgment involving fraud by a provider:

(a) The period(s) of sentence, probation, and other sanction imposed by court order against the provider may be presumed reasonable and adopted as the administrative period of exclusion or suspension under CHAMPUS, unless aggravating or mitigating factors exist.

(b) If any aggravating factors exist, then cause exists for the Director, OCHAMPUS, or a designee, to consider the factors set forth in subparagraph G.1.b.(2), below, in imposing a period of administrative exclusion or suspension in excess of the period(s) of sentence, probation, and/or other sanctions imposed by court order. Examples of aggravating factors include, but are not limited to:

1 An administrative determination by the Director, OCHAMPUS, or a designee, that the basis for administrative exclusion or suspension includes an act(s) of fraud or abuse under CHAMPUS in addition to, or unrelated to, an act(s) of fraud included in the court conviction or civil judgment.

2 The fraudulent act(s) involved in the criminal conviction or civil judgment, or similar acts, were committed over a significant period of time; that is, one year or more.

3 The act(s) of fraud or abuse had an adverse physical, mental, or financial impact on one or more CHAMPUS beneficiaries.

4 The loss or potential loss to CHAMPUS is over \$5,000. The entire amount of loss or potential loss to CHAMPUS due to acts of fraud and abuse will be considered, in addition to the amount of loss involved in the court conviction or civil judgment, regardless of whether full or partial restitution has been made to CHAMPUS.

5 The provider has a prior court record, criminal or civil, or administrative record or finding of fraud or abuse.

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(c) If any mitigating factors exist, then cause may exist for the Director, OCHAMPUS, or a designee, to reduce a period of administrative exclusion or suspension from any period(s) imposed by court conviction or civil judgment. Only the existence of either of the following two factors may be considered in mitigation:

1 The criminal conviction or civil judgment only involved three or fewer misdemeanor offenses, and the total of the estimated losses incurred (including any loss from act(s) not involved in the conviction or judgment) is less than \$1,000, regardless of whether full or partial restitution has been made.

2 The criminal or civil court proceedings establish that the provider had a mental, emotional or physical condition, prior to or contemporaneous with the commission of the act(s), that reduced the provider's criminal or civil culpability.

(2) The Director, OCHAMPUS, or a designee, may consider the following factors in determining a reasonable period of exclusion or suspension of a provider under CHAMPUS:

(a) The nature of the claims and the circumstances under which they were presented;

(b) The degree of culpability;

(c) History of prior offenses (including whether claims were submitted while the provider was either excluded or suspended pursuant to prior administrative action);

(d) Number of claims involved;

(e) Dollar amount of claims involved;

(f) Whether, if a crime was involved, it was a felony or misdemeanor;

(g) If patients were injured financially, mentally, or physically; the number of patients; and the seriousness of the injury(ies);

(h) The previous record of the provider under CHAMPUS;

(i) Whether restitution has been made or arrangements for repayment accepted by the Government;

(j) Whether the provider has resolved the conflict of interest situations or implemented procedures acceptable to the Director, OCHAMPUS, or a designee, which will prevent conflict of interest in the future; and,

(k) Such other factors as may be deemed appropriate.

2. Terminations. When a provider's status as an authorized CHAMPUS provider is ended, other than through exclusion or suspension, the termination is based on a finding that the provider does not meet the qualifications to be an authorized provider, as set forth in this Regulation. Therefore, the period of termination in all cases will be indefinite and will end only after the provider has successfully met the established qualifications for authorized provider status under CHAMPUS and has been reinstated under CHAMPUS. Except as otherwise provided in this subparagraph, the following guidelines control the termination of authorized CHAMPUS provider status for a provider whose license to practice (or, in the case of an institutional provider, to operate) has been temporarily or permanently suspended or revoked by the jurisdiction issuing the license.

a. Termination of the provider under CHAMPUS shall continue even if the provider obtains a license to practice in a second jurisdiction during the period of suspension or revocation of the provider's license by the original licensing jurisdiction. A provider who has licenses to practice in two or more jurisdictions and has one or more license(s) suspended or revoked will also be terminated as a CHAMPUS provider.

(1) Professional providers shall remain terminated from the CHAMPUS until the jurisdiction(s) suspending or revoking the provider's license(s) to practice restores it or removes the impediment to restoration.

(2) Institutional providers shall remain terminated under CHAMPUS until their license is restored. In the event the facility is sold, transferred, or reorganized as a new legal entity, and a license issued under a new name or to a different legal entity, the new entity must submit an application to be an authorized CHAMPUS provider.

b. If the CHAMPUS provider status is terminated due to the loss of the provider's license, the effective date shall be retroactive to the date the provider lost the license; however, in the case of a professional provider who has licenses in two or more jurisdictions and submitted claims from a jurisdiction from which he/she had a valid license, the effective date of the termination will be 15 calendar days from the date of the written initial determination of termination for purposes of claims from the jurisdiction in which the provider still has a valid license.

H. PROCEDURES FOR INITIATING AND IMPLEMENTING THE ADMINISTRATIVE REMEDIES

1. Temporary suspension of claims processing.

a. In general, temporary suspension of claims processing may be invoked to protect the interests of the Government for a period reasonably necessary to complete investigation or appropriate criminal, civil, and administrative proceedings. The temporary suspension only delays the ultimate payment of otherwise appropriate claims. When claims processing involving a participating provider is temporarily suspended, the participation agreement remains in full force and the provider cannot repudiate the agreement because of the delay in the final disposition of the claim(s). Once it has been determined appropriate to end the temporary suspension of claims processing, CHAMPUS claims which were the subject of the

suspension and which are otherwise determined to be in compliance with the requirements of law and regulation, will be processed to completion and payment unless such action is deemed inappropriate as a result of criminal, civil, or administrative remedies ultimately invoked in the case.

b. When adequate evidence exists to determine that a provider or beneficiary is submitting fraudulent or false claims or claims involving practices that may be fraud or abuse as defined by this Regulation, the Director, OCHAMPUS, or a designee, may suspend CHAMPUS claims processing (in whole or in part) for claims submitted by the beneficiary or any CHAMPUS claims involving care furnished by the provider. The temporary suspension of claims processing for care furnished by a provider may be invoked against all such claims, whether or not the claims are submitted by the beneficiary or by the provider as a participating CHAMPUS provider. In cases involving a provider, notice of the suspension of claims processing may also be given to the beneficiary community either directly or indirectly through notice to appropriate military facilities, health benefit advisors, and the information or news media.

(1) Adequate evidence is any information sufficient to support the reasonable belief that a particular act or omission has occurred.

(2) Indictment or any other initiation of criminal charges, filing of a complaint for civil fraud, issuance of an administrative complaint under the Program Fraud Civil Remedies Act, or issuance of an initial determination under this Regulation for submitting fraudulent or false claims or claims involving practices that may be fraud or abuse as defined by this Regulation, shall constitute adequate evidence for invoking temporary suspension of claims processing.

c. The Director, OCHAMPUS, or a designee, may suspend CHAMPUS claims processing without first notifying the provider or beneficiary of the intent to suspend payments. Following a decision to invoke a temporary suspension, however, the Director, OCHAMPUS, or a designee, shall issue written notice advising the provider or beneficiary that:

(1) A temporary suspension of claims processing has been ordered and a statement of the basis of the decision to suspend payment. Unless the suspension is based on any of the actions set forth in subparagraph H.1.b.(2) above, the notice shall describe the suspected acts or omissions in terms sufficient to place the provider or beneficiary on notice without disclosing the Government's evidence.

(2) Within 30 days (or, upon written request received by OCHAMPUS during the 30 days and for good cause shown, within 60 days) from the date of the notice, the provider or beneficiary may:

(a) Submit to the Director, OCHAMPUS, or a designee, in writing, information (including documentary evidence) and argument in opposition to the suspension, provided the additional specific information raises a genuine dispute over the material facts, or

(b) Submit a written request to present in person evidence or argument to the Director, OCHAMPUS, or a designee. All such presentations shall be made at the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) in Aurora, Colorado, at the provider's or beneficiary's own expense.

(3) Additional proceedings to determine disputed material facts may be conducted unless:

(a) the suspension is based on any of the actions set forth in subparagraph H.1.b.(2) above, or,

(b) a determination is made, on the basis of the advice of the responsible Government official (e.g., an official of the Department of Justice, the designated Reviewing Official under the Program Fraud Civil Remedies Act, etc.), that the substantial interests of the Government in pending or contemplated legal or administrative proceedings based on the same facts as the suspension would be prejudiced.

d. If the beneficiary or provider submits, either in writing or in person, additional information or argument in opposition to the suspension, the Director, OCHAMPUS, or a designee, shall issue a suspending official's decision which modifies, terminates, or leaves in force the suspension of claims processing. However, a decision to terminate or modify the suspension shall be without prejudice to the subsequent imposition of suspension of claims processing, imposition of sanctions under this chapter, the recovery of erroneous payments under Chapter 11 of this Regulation, or any other administrative or legal action authorized by law or regulation. The suspending official's decision shall be in writing as follows:

(1) A written decision based on all the information in the administrative record, including any submission by the beneficiary or provider, shall be final in a case:

(a) based on any of the actions set forth in subparagraph H.1.b.(2) above,

(b) in which the beneficiary's or provider's submission does not raise a genuine dispute over material facts, or

(c) in which additional proceedings to determine disputed material facts have been denied on the basis of advice of a responsible Government official that the substantial interests of the Government in pending or contemplated legal or administrative proceedings would be prejudiced.

(2) In a case in which additional proceedings are necessary as to disputed material facts, the suspending official's decision shall advise the beneficiary or provider that the case has been referred for handling as a hearing under Chapter 10 of this Regulation.

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e. A suspension of claims processing may be modified or terminated for reasons such as:

- (1) Newly discovered evidence;
- (2) Elimination of any of the causes for which the suspension was invoked; or
- (3) Other reasons the Director, OCHAMPUS, or a designee, deems appropriate.

f. A suspension of claims processing shall be for a temporary period pending the completion of investigation and any ensuing legal or administrative proceedings, unless sooner terminated by the Director, OCHAMPUS, or a designee, or as provided in this paragraph.

(1) If legal or administrative proceedings are not initiated within 12 months after the date of the suspension notice, the suspension shall be terminated unless the Government official responsible for initiation of the legal or administrative action requests its extension, in which case it may be extended for an additional 6 months. In no event may a suspension extend beyond 18 months, unless legal or administrative proceedings have been initiated during that period.

(2) The Director, OCHAMPUS, or a designee, shall notify the Government official responsible for initiation of the legal or administrative action of the proposed termination of the suspension, at least 30 days before the 12-month period expires, to give the official an opportunity to request an extension.

2. Notice of proposed administrative sanction.

a. A provider shall be notified in writing of the proposed action to exclude, suspend, or terminate the provider's status as an authorized CHAMPUS provider.

(1) The notice shall state which sanction will be taken and the effective date of that sanction as determined in accordance with the provisions of this Regulation.

(2) The notice shall inform the provider of the situation(s), circumstance(s), or action(s) which form the basis for the proposed sanction and reference the paragraph of this Regulation under which the administrative action is being taken.

(3) The notice will be sent to the provider's last known business or office address (or home address if there is no known business address.)

(4) The notice shall offer the provider an opportunity to respond within 30 days (or, upon written request received by OCHAMPUS during the 30 days and for good cause shown, within 60 days) from the date on the notice with either:

(a) Documentary evidence and written argument contesting the proposed action; or,

(b) A written request to present in person evidence or argument to the Director, OCHAMPUS, or a designee. All such presentations shall be made at the Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) in Aurora, Colorado, at the provider's own expense.

3. Initial determination.

a. If, after the provider has exhausted, or failed to comply with, the procedures specified in subsection H.2. above, the Director, OCHAMPUS, or a designee, decides to invoke an administrative remedy of exclusion, suspension, or termination of a provider under CHAMPUS, written notice of the decision will be sent to the provider by certified mail. Except in those cases where the sanction has a retroactive effective date, the written notice shall be dated no later than 15 days before the decision becomes effective. For terminations under subparagraph F.2.b.(2) of this chapter, the initial determination may be issued without first implementing or exhausting the procedures specified in subsection H.2. above.

b. The initial determination shall include:

(1) A statement of the sanction being invoked;

(2) A statement of the effective date of the sanction;

(3) A statement of the facts, circumstances, or actions which form the basis for the sanction and a discussion of any information submitted by the provider relevant to the sanction;

(4) A statement of the factors considered in determining the period of sanction;

(5) The earliest date on which a request for reinstatement under CHAMPUS will be accepted;

(6) The requirements and procedures for reinstatement; and,

(7) Notice of the available hearing upon request of the sanctioned provider.

4. Reinstatement procedures.

a. Restitution.

(1) There is no entitlement under CHAMPUS for payment (cost-sharing) of any claim that involves either criminal or civil fraud as defined by law, or fraud or abuse or conflict of interest as defined by this Regulation. In addition, except as specifically provided in this Regulation, there is no entitlement under CHAMPUS for payment (cost-sharing) of any claim

for services or supplies furnished by a provider who does not meet the requirements to be an authorized CHAMPUS provider. In any of the situations described above, CHAMPUS payment shall be denied whether the claim is submitted by the provider as a participating claim or by the beneficiary for reimbursement. If an erroneous payment has been issued in any such case, collection of the payment will be processed under Chapter 11 of this Regulation.

(2) If the Government has made erroneous payments to a provider because of claims involving fraud, abuse, or conflicts of interest, restitution of the erroneous payments shall be made before a request for reinstatement as a CHAMPUS authorized provider will be considered. Without restitution or resolution of the debt under Chapter 11 of this Regulation, a provider shall not be reinstated as an authorized CHAMPUS provider. This is not an appealable issue under Chapter 10 of this Regulation.

(3) For purposes of authorization as a CHAMPUS provider, a provider who is excluded or suspended under this chapter and who submits participating claims for services furnished on or after the effective date of the exclusion or suspension is considered to have forfeited or waived any right or entitlement to bill the beneficiary for the care involved in the claims. Similarly, because a provider is expected to know the CHAMPUS requirements for qualification as an authorized provider, any participating provider who fails to meet the qualification requirements for CHAMPUS is considered to have forfeited or waived any right or entitlement to bill the beneficiary for the care involved in the CHAMPUS claims. If, in either situation, the provider bills the beneficiary, restitution to the beneficiary may be required by the Director, OCHAMPUS, or a designee, as a condition for consideration of reinstatement as a CHAMPUS authorized provider.

b. Terminated providers. A terminated provider who subsequently achieves the minimum qualifications to be an authorized CHAMPUS provider or who has had his/her license reinstated or the impediment to reinstatement removed by the appropriate licensing jurisdiction may submit a written request for reinstatement under CHAMPUS to the Director, OCHAMPUS, or a designee. If restitution or proper reinstatement of license is not at issue, the Director, OCHAMPUS, or a designee, will process the request for reinstatement under the procedures established for initial requests for authorized CHAMPUS provider status.

c. Providers (other than entities) excluded or suspended under CHAMPUS.

(1) A provider excluded or suspended from CHAMPUS (other than an entity excluded under paragraph F.1.a. of this chapter) may seek reinstatement by submitting a written request to the Director, OCHAMPUS, or a designee, any time after the date specified in the notice of exclusion or suspension or any earlier date specified in an appeal decision issued in the provider's appeal under Chapter 10 of this Regulation. The request for reinstatement shall include:

(a) Documentation sufficient to establish the provider's qualifications under this Regulation to be a CHAMPUS authorized provider;

(b) A statement from the provider setting forth the reasons why the provider should be reinstated, accompanied by written statements from professional associates, peer review bodies, and/or probation officers (if appropriate), attesting to their belief that the violations that led to exclusion or suspension will not be repeated.

(2) A provider entity excluded from CHAMPUS under paragraph F.1.a. of this chapter may seek reinstatement by submitting a written request to the Director, OCHAMPUS, or a designee, with documentation sufficient to establish the provider's qualifications under this Regulation to be a CHAMPUS authorized provider and either:

(a) Documentation showing the CHAMPUS reinstatement of the excluded individual provider whose conviction led to the CHAMPUS exclusion or suspension of the provider entity; or

(b) Documentation acceptable to the Director, OCHAMPUS, or a designee, that shows that the individual whose conviction led to the entity's exclusion:

1 Has reduced his or her ownership or control interest in the entity below 5 percent; or

2 Is no longer an officer, director, agent or managing employee of the entity; or

3 Continues to maintain a 5 percent or more ownership or control interest in such entity, and that the entity due to circumstances beyond its control, is unable to obtain a divestiture.

NOTE: Under subparagraph H.4.c.(2)(b) above, the request for reinstatement may be submitted any time prior to the date specified in the notice of exclusion or suspension or an earlier date specified in the appeal decision issued under Chapter 10 of this Regulation.

d. Action on request for reinstatement. In order to reinstate a provider as a CHAMPUS authorized provider, the Director, OCHAMPUS, or a designee, must determine that:

(1) The provider meets all requirements under this Regulation to be an authorized CHAMPUS provider;

(2) No additional criminal, civil, or administrative action has been taken or is being considered which could subject the provider to exclusion, suspension, or termination under this chapter;

(3) In the case of a provider entity, verification has been made of the divestiture or termination of the owner, controlling party,

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officer, director, agent or managing employee whose conviction led to the entity's exclusion, or that the provider entity should be reinstated because the entity, due to circumstances beyond its control, cannot obtain a divestiture of the 5 percent or more ownership or controlling interest by the convicted party.

e. Notice of action on request for reinstatement.

(1) Notice of approval of request. If the Director, OCHAMPUS, or a designee, approves the request for reinstatement, he or she will:

(a) Give written notice to the sanctioned party specifying the date when the authorized provider status under CHAMPUS may resume; and

(b) Give notice to those agencies and groups that were originally notified, in accordance with section K. of this chapter, of the imposition of the sanction. General notice may also be given to beneficiaries and other parties as deemed appropriate by the Director, OCHAMPUS, or a designee.

(2) Notice of denial of request. If the Director, OCHAMPUS, or a designee, does not approve the request for reinstatement, written notice will be given to the provider. If established procedures for processing initial requests for authorized provider status are used to review the request for reinstatement, the established procedures may be used to provide the notice that the provider does not meet requirements of this Regulation for such status. If the provider continues to be excluded, suspended, or terminated under the provisions of this chapter, the procedures set forth in section H. may be followed in denying the provider's request for reinstatement.

5. Reversed or vacated convictions or civil judgments involving CHAMPUS fraud.

a. If a CHAMPUS provider is excluded or suspended solely on the basis of a criminal conviction or civil judgment involving a CHAMPUS fraud and the conviction or judgment is reversed or vacated on appeal, CHAMPUS will void the exclusion of a provider. Such action will not preclude the initiation of additional independent administrative action under this chapter or any other administrative remedy based on the same facts or events which were the subject of the criminal conviction or civil judgment.

b. If an exclusion is voided under paragraph a., above, CHAMPUS will make payment, either to the provider or the beneficiary (if the claim was not a participating claim) for otherwise authorized services under CHAMPUS that are furnished or performed during the period of exclusion.

c. CHAMPUS will also void the exclusion of any entity that was excluded under paragraph F.1.a. of this chapter based solely on an individual's conviction that has been reversed or vacated on appeal.

d. When CHAMPUS voids the exclusion of a provider or an entity, notice will be given to the agencies and others that were originally notified, in accordance with section K. of this chapter.

I. EVIDENCE REQUIRED FOR DETERMINATIONS TO INVOKE ADMINISTRATIVE REMEDIES

1. General. Any relevant evidence may be used by the Director, OCHAMPUS, or a designee, if it is the type of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule that might make improper the admission of such evidence over objection in civil or criminal courts.

2. Types of evidence. The types of evidence which the Director, OCHAMPUS, or a designee, may rely on in reaching a determination to invoke administrative remedies under this chapter include but are not limited to the following:

a. Results of audits conducted by or on behalf of the Government. Such audits can include the results of 100 percent review of claims and related records or a statistically valid sample audit of the claims or records. A statistical sampling shall constitute prima facie evidence of the number and amount of claims and the instances of fraud, abuse, or conflict of interest.

b. Reports, including sanction reports, from various sources including a peer review organization (PRO) for the area served by the provider; state or local licensing or certification authorities; peer or medical review consultants of the Government, including consultants for Government contractors; state or local professional societies; or other sources deemed appropriate by the Director, OCHAMPUS, or a designee.

c. Orders or documents issued by Federal, state, foreign, or other courts of competent jurisdiction which issue findings and/or criminal convictions or civil judgments involving the provider, and administrative rulings, findings, or determinations by any agency of the Federal Government, a state, or local licensing or certification authority regarding the provider's status with that agency or authority.

J. SUSPENDING ADMINISTRATIVE ACTION

1. All or any administrative action may be suspended by the Director, OCHAMPUS, or a designee, pending action in the case by the Department of Defense-Inspector General, Defense Criminal Investigative Service, or the Department of Justice (including the responsible United States Attorney). However, action by the Department of Defense-Inspector General or the Department of Justice, including investigation, criminal prosecution, or civil litigation, does not preclude administrative action by OCHAMPUS.

2. The normal OCHAMPUS procedure is to suspend action on the administrative process pending an investigation by the Department of Defense-Inspector General or final disposition by the Department of Justice.

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3. Though OCHAMPUS administrative action is taken independently of any action by the Department of Defense-Inspector General or by the Department of Justice, once a case is forwarded to the Department of Defense-Inspector General or the Department of Justice for legal action (criminal or civil), administrative action may be held in abeyance.

4. In some instances there may be dual jurisdiction between agencies; as in, for example, the joint regulations issued by the Department of Justice and the Government Accounting Office regarding debt collection.

K. NOTICE TO OTHER AGENCIES

1. When CHAMPUS excludes, suspends, or terminates a provider, the Director, OCHAMPUS, or a designee, will notify other appropriate agencies (for example, the Department of Health and Human Services and the state licensing agency that issued the provider's license to practice) that the individual has been excluded, suspended, or terminated as an authorized provider under CHAMPUS. An exclusion, suspension, or termination action is considered a public record. Such notice can include the notices and determinations sent to the suspended provider and other public documents such as testimony given at a hearing or exhibits or depositions given in a lawsuit or hearing. Notice may also be given to Uniformed Services Military Treatment Facilities, Health Benefit Advisors, beneficiaries and sponsors, the news media, and institutional providers if inpatient care was involved.

2. If CHAMPUS has temporarily suspended claims processing, notice of such action normally will be given to the affected provider and Uniformed Services Medical Treatment Facilities, Health Benefits Advisors, beneficiaries, and sponsors. Notice may also be given to any information or news media and any other individual, professional provider, or institutional provider, as deemed appropriate. However, since a "temporary suspension of claims processing" is by definition not a final or formal agency action, the basis for the action generally will not be disclosed. It is noted that the basis for the action can be a result of questions arising from routine audits to investigation of possible criminal violations.

L. COMPROMISE, SETTLEMENT, AND RESOLUTION AUTHORITY

1. In lieu of invoking any remedy provided by this chapter, the Director, OCHAMPUS, or a designee, may elect to enter into an agreement with the provider intended to correct the situation within an established time period and subject to any remedies deemed appropriate by the Director, OCHAMPUS, or a designee.

2. When it is in the best interest of CHAMPUS, the Director, OCHAMPUS, has the resolution authority to waive an action or enter into compromise or settlement of administrative actions taken under this chapter.

CHAPTER 10
APPEAL AND HEARING PROCEDURES

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CHAPTER 10
APPEAL AND HEARING PROCEDURES

A. GENERAL

This chapter sets forth the policies and procedures for appealing decisions made by OCHAMPUS, OCHAMPUSEUR, and CHAMPUS contractors adversely affecting the rights and liabilities of CHAMPUS beneficiaries, CHAMPUS participating providers, and providers denied the status of authorized provider under CHAMPUS. An appeal under CHAMPUS is an administrative review of program determinations made under the provisions of law and regulation. An appeal cannot challenge the propriety, equity, or legality of any provision of law or regulation.

1. Initial determination

a. Notice of initial determination and right to appeal

(1) OCHAMPUS, OCHAMPUSEUR, and CHAMPUS contractors shall mail notices of initial determinations to the affected provider or CHAMPUS beneficiary (or representative) at the last known address. For beneficiaries who are under 18 years of age or who are incompetent, a notice issued to the parent, guardian, or other representative, under established CHAMPUS procedures, constitutes notice to the beneficiary.

(2) CHAMPUS contractors and OCHAMPUSEUR shall notify a provider of an initial determination on a claim only if the provider participated in the claim. (See Chapter 7 of this Regulation.)

(3) CHAMPUS peer review organizations shall notify providers and fiscal intermediaries of a denial determination on a claim.

(4) Notice of an initial determination on a claim processed by a CHAMPUS contractor or OCHAMPUSEUR normally will be made on a CHAMPUS Explanation of Benefits (CEOB) form.

(5) Each notice of an initial determination on a request for benefit authorization, a request by a provider for approval as an authorized CHAMPUS provider, or a decision to disqualify or exclude a provider as an authorized provider under CHAMPUS shall state the reason for the determination and the underlying facts supporting the determination.

(6) In any case when the initial determination is adverse to the beneficiary or participating provider, or to the provider seeking approval as an authorized CHAMPUS provider, the notice shall include a statement of the beneficiary's or provider's right to appeal the determination. The procedure for filing the appeal also shall be explained.

b. Effect of initial determination. The initial determination is final unless appealed in accordance with this chapter, or unless the initial determination is reopened by OCHAMPUS, the CHAMPUS contractor, or the CHAMPUS peer review organization.

2. Participation in an appeal. Participation in an appeal is limited to any party to the initial determination, including CHAMPUS, and authorized representatives of the parties. Any party to the initial determination, except CHAMPUS, may appeal an adverse determination. The appealing party is the party who actually files the appeal.

a. Parties to the initial determination. For purposes of the CHAMPUS appeals and hearing procedures, the following are not parties to an initial determination and are not entitled to administrative review under this chapter.

(1) A provider disqualified or excluded as an authorized provider under CHAMPUS based on a determination of abuse or fraudulent practices or procedures under another Federal or federally funded program is not a party to the CHAMPUS action and may not appeal under this chapter.

(2) A beneficiary who has an interest in receiving care or has received care from a particular provider cannot be an appealing party regarding the exclusion, suspension, or termination of the provider under Chapter 9 of this Regulation.

(3) A sponsor or parent of a beneficiary under 18 years of age or guardian of an incompetent beneficiary is not a party to the initial determination and may not serve as the appealing party, although such persons may represent the appealing party in an appeal.

(4) A third party, such as an insurance company, is not a party to the initial determination and is not entitled to appeal even though it may have an indirect interest in the initial determination.

(5) A nonparticipating provider is not a party to the initial determination and may not appeal.

b. Representative. Any party to the initial determination may appoint a representative to act on behalf of the party in connection with an appeal. Generally, the parent of a minor beneficiary and the legally appointed guardian of an incompetent beneficiary shall be presumed to have been appointed representative without specific designation by the beneficiary.

(1) The representative shall have the same authority as the party to the appeal and notice given to the representative shall constitute notice required to be given to the party under this Regulation.

(2) To avoid possible conflicts of interest, an officer or employee of the United States, such as an employee or member of a Uniformed Service, including an employee or staff member of a Uniformed Service legal office, or a CHAMPUS advisor, subject to the exceptions in 18 U.S.C. 205 (reference (hh)), is not eligible to serve as a representative. An exception usually is made for an employee or member of a Uniformed Service who represents an immediate family member. In addition, the Director, OCHAMPUS, or designee, may appoint an officer or employee of the United States as the CHAMPUS representative at a hearing.

3. Burden of proof. The burden of proof is on the appealing party to establish affirmatively by substantial evidence the appealing party's entitlement under law and this Regulation to the authorization of CHAMPUS benefits, approval of authorized CHAMPUS provider status, or removal of sanctions imposed under Chapter 9 of this Regulation. If a presumption

exists under the provisions of this Regulation or information constitutes prima facie evidence under the provisions of this Regulation, the appealing party must produce evidence reasonably sufficient to rebut the presumption or prima facie evidence as part of the appealing party's burden of proof. CHAMPUS shall not pay any part of the cost or fee, including attorney fees, associated with producing or submitting evidence in support of an appeal.

4. Evidence in appeal and hearing cases. Any relevant evidence may be used in the administrative appeal and hearing process if it is the type of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule that might make improper the admission of such evidence over objection in civil or criminal courts.

5. Late filing. If a request for reconsideration, formal review, or hearings is filed after the time permitted in this chapter, written notice shall be issued denying the request. Late filing may be permitted only if the appealing party reasonably can demonstrate to the satisfaction of the Director, OCHAMPUS, or a designee, that the timely filing of the request was not feasible due to extraordinary circumstances over which the appealing party had no practical control. Each request for an exception to the filing requirement will be considered on its own merits. The decision of the Director, OCHAMPUS, or a designee, on the request for an exception to the filing requirement shall be final.

6. Appealable issue. An appealable issue is required in order for an adverse determination to be appealed under the provisions of this chapter. Examples of issues that are not appealable under this chapter include:

- a. A dispute regarding a requirement of the law or regulation.
- b. The amount of the CHAMPUS-determined allowable cost or charge, since the methodology for determining allowable costs or charges is established by this Regulation.
- c. The establishment of diagnosis-related groups (DRGs), or the methodology for the classification of inpatient discharges within the DRGs, or the weighting factors that reflect the relative hospital resources used with respect to discharges within each DRG, since each of these is established by this Regulation.
- d. Certain other issues on the basis that the authority for the initial determination is not vested in CHAMPUS. Such issues include but are not limited to the following examples:

(1) Determination of a person's eligibility as a CHAMPUS beneficiary is the responsibility of the appropriate Uniformed Service. Although OCHAMPUS, OCHAMPUSEUR, and CHAMPUS contractors must make determinations concerning a beneficiary's eligibility in order to ensure proper disbursement of appropriated funds on each CHAMPUS claim processed, ultimate responsibility for resolving a beneficiary's eligibility rests with the Uniformed Services. Accordingly, disputed question of fact concerning a

beneficiary's eligibility will not be considered an appealable issue under the provisions of this chapter, but shall be resolved in accordance with Chapter 3 of this Regulation.

(2) Similarly, decisions relating to the issuance of a Nonavailability Statement (DD Form 1251) in each case are made by the Uniformed Services. Disputes over the need for a Nonavailability Statement or a refusal to issue a Nonavailability Statement are not appealable under this chapter. The one exception is when a dispute arises over whether the facts of the case demonstrate a medical emergency for which a Nonavailability Statement is not required. Denial of payment in this one situation is an appealable issue.

(3) Any sanction, including the period of the sanction, imposed under Chapter 9 of this Regulation which is based solely on a provider's exclusion or suspension by another agency of the Federal Government, a state, or a local licensing authority is not appealable under this chapter. The provider must exhaust administrative appeal rights offered by the other agency that made the initial determination to exclude or suspend the provider. Similarly, any sanction imposed under Chapter 9 which is based solely on a criminal conviction or civil judgment against the provider is not appealable under this chapter. If the sanction imposed under Chapter 9 is not based solely on the provider's criminal conviction or civil judgment or on the provider's exclusion or suspension by another agency of the Federal Government, a state, or a local licensing authority, that portion of the CHAMPUS administrative determination which is in addition to the criminal conviction/civil judgment or exclusion/suspension by the other agency may be appealed under this chapter.

e. A decision by the Director, OCHAMPUS, or a designee, as a suspending official when the decision is final under the provisions of Chapter 9, Section H.1.d.(1).

7. Amount in dispute. An amount in dispute is required for an adverse determination to be appealed under the provisions of this chapter, except as set forth below.

a. The amount in dispute is calculated as the amount of money CHAMPUS would pay if the services and supplies involved in dispute were determined to be authorized CHAMPUS benefits. Examples of amounts of money that are excluded by the Regulation from CHAMPUS payments for authorized benefits include, but are not limited to:

(1) Amounts in excess of the CHAMPUS-determined allowable charge or cost.

(2) The beneficiary's CHAMPUS deductible and cost-share amounts.

(3) Amounts that the CHAMPUS beneficiary, or parent, guardian, or other responsible person has no legal obligation to pay.

(4) Amounts excluded under the provisions of Chapter 8 of this Regulation.

b. The amount of dispute for appeals involving a denial of a request for authorization in advance of obtaining care shall be the estimated allowable charge or cost for the services requested.

c. There is no requirement for an amount in dispute when the appealable issue involves a denial of a provider's request for approval as an authorized CHAMPUS provider; the determination to exclude, suspend, or terminate a provider's authorized CHAMPUS provider status; or the determination of circumvention of the CHAMPUS DRG-based payment system by a provider.

d. Individual claims may be combined to meet the required amount in dispute if all of the following exist:

(1) The claims involve the same beneficiary.

(2) The claims involve the same issue.

(3) At least one of the claims so combined has had a reconsideration decision issued by OCHAMPUSEUR, a CHAMPUS contractor, or a CHAMPUS peer review organization.

NOTE: A request for administrative review under this appeal process which involves a dispute regarding a requirement of law or regulation (paragraph A.6.a. above) or does not involve a sufficient amount in dispute (subsection A.7. above) may not be rejected at the reconsideration level of appeal. However, an appeal shall involve an appealable issue and sufficient amount in dispute under these subsections to be granted a formal review or hearing.

8. Levels of appeal. The sequence and procedures of a CHAMPUS appeal vary, depending on whether the initial determination was made by OCHAMPUS, OCHAMPUSEUR, a CHAMPUS contractor, or a CHAMPUS peer review organization.

a. Appeal levels for initial determination made by OCHAMPUSEUR, CHAMPUS contractor, or CHAMPUS peer review organization.

(1) Reconsideration by OCHAMPUSEUR, CHAMPUS contractor, or CHAMPUS peer review organization.

(2) Formal review by OCHAMPUS (except for CHAMPUS peer review organization reconsiderations).

(3) Hearing.

b. Appeal levels for initial determination made by OCHAMPUS

(1) Formal review by OCHAMPUS except (a) initial determinations involving the suspension of claims processing where the Director, OCHAMPUS, or a designee, determines that additional proceedings are necessary as to disputed material facts and the suspending official's decision is not final under the provisions of Chapter 9, Section H.1.d.(1) or (b) initial determinations involving the sanctioning (exclusion, suspension, or termination) of CHAMPUS providers. Initial determinations involving these matters shall be appealed directly to the hearing level.

(2) Hearing.

9. Appeal decision. An appeal decision at any level may address all pertinent issues which arise under the appeal or are otherwise presented by the information in the case record (for example, the entire episode of care in the appeal), and shall not be limited to addressing the specific issue appealed by a party. In the case of sanctions imposed under Chapter 9, the final decision may affirm, increase or reduce the sanction period imposed by CHAMPUS, or otherwise modify or reverse the imposition of the sanction.

B. RECONSIDERATION

Any party to the initial determination made by OCHAMPUSEUR, the CHAMPUS contractor, or a CHAMPUS peer review organization may request a reconsideration.

1. Requesting a reconsideration

a. Written request required. The request must be in writing, shall state the specific matter in dispute, and shall include a copy of the notice of initial determination (such as the CEOB form) made by OCHAMPUSEUR, the CHAMPUS contractor, or the CHAMPUS peer review organization.

b. Where to file. The request shall be submitted to the office that made the initial determination (i.e., OCHAMPUSEUR, the CHAMPUS contractor, or the CHAMPUS peer review organization) or any other CHAMPUS contractor designated in the notice of initial determination.

c. Allowed time to file. The request must be mailed within 90 days after the date of the notice of initial determination.

d. Official filing date. A request for a reconsideration shall be deemed filed on the date it is mailed and postmarked. If the request does not have a postmark, it shall be deemed filed on the date received by OCHAMPUSEUR, the CHAMPUS contractor or the CHAMPUS peer review organization.

2. The reconsideration process. The purpose of the reconsideration is to determine whether the initial determination was made in accordance with law, regulation, policies, and guidelines in effect at the time the care was provided or requested, or at the time of the initial determination and/or reconsideration decision involving a provider request for approval as an authorized provider under CHAMPUS. The reconsideration is performed by a member of the OCHAMPUSEUR, CHAMPUS contractor, or CHAMPUS peer review organization staff who was not involved in making the initial determination and is a thorough and independent review of the case. The reconsideration is based on the information submitted that led to the initial determination, plus any additional information that the appealing party may submit or OCHAMPUSEUR, the CHAMPUS contractor, or CHAMPUS peer review organization may obtain.

3. Timeliness of reconsideration determination. OCHAMPUSEUR, the CHAMPUS contractor, or CHAMPUS peer review organization normally shall issue its reconsideration determination no later than 60 days from the date of receipt of the request for reconsideration by OCHAMPUSEUR, the CHAMPUS contractor, or the CHAMPUS peer review organization.

4. Notice of reconsideration determination. OCHAMPUSEUR, the CHAMPUS contractor, or the CHAMPUS peer review organization shall issue a written notice of the reconsideration determination to the appealing party at his or her last known address. The notice of the reconsideration determination must contain the following elements:

- a. A statement of the issue or issues under appeal.
- b. The provisions of law, regulation, policies, and guidelines that apply to the issue or issues under appeal.
- c. A discussion of the original and additional information that is relevant to the issue or issues under appeal.
- d. Whether the reconsideration upholds the initial determination or reverses it, in whole or in part, and the rationale for the action.
- e. A statement of the right to appeal further in any case when the reconsideration determination is less than fully favorable to the appealing party and the amount in dispute is \$50 or more.

5. Effect of reconsideration determination. The reconsideration determination is final if either of the following exist:

- a. The amount in dispute is less than \$50.
- b. Appeal rights have been offered, but a request for formal review is not received by OCHAMPUS within 60 days of the date of the notice of the reconsideration determination.

C. FORMAL REVIEW

Except as explained below, any party to an initial determination made by OCHAMPUS, or a reconsideration determination made by the CHAMPUS contractor may request a formal review by OCHAMPUS if the party is dissatisfied with the initial or reconsideration determination unless the initial or reconsideration determination (1) is final under paragraph (b)(5) above; (2) involves the sanctioning of a provider by the exclusion, suspension or termination of authorized provider status; (3) involves a written decision issued pursuant to Section 199.9, paragraph (h)(1)(iv)(A) regarding the temporary suspension of claims processing; or (4) involves a reconsideration determination by a CHAMPUS peer review organization. A hearing, but not a formal review level of appeal, may be available to a party to an initial determination involving the sanctioning of a provider or to a party to a written decision involving a temporary suspension of claims processing. A beneficiary (or an authorized representative of a beneficiary), but not a provider, may request a hearing, but not a formal review, of a reconsideration determination made by a CHAMPUS peer review organization.

1. Requesting a formal review

- a. Written request required. The request must be in writing, shall state the specific matter in dispute, shall include copies of the written determination

(notice of reconsideration determination or OCHAMPUS initial determination) being appealed, and shall include any additional information or documents not submitted previously.

b. Where to file. The request shall be submitted to the Chief, Appeals and Hearings, OCHAMPUS, Aurora, Colorado 80045-6900.

c. Allowed time to file. The request shall be mailed within 60 days after the date of the notice of the reconsideration determination or OCHAMPUS initial determination being appealed.

d. Official filing date. A request for a formal review shall be deemed filed on the date it is mailed and postmarked. If the request does not have a postmark, it shall be deemed filed on the date received by OCHAMPUS.

2. The formal review process. The purpose of the formal review is to determine whether the initial determination or reconsideration determination was made in accordance with law, regulation, policies, and guidelines in effect at the time the care was provided or requested or at the time of the initial determination, reconsideration, or formal review decision involving a provider request for approval as an authorized CHAMPUS provider. The formal review is performed by the Chief, Appeals and Hearings, OCHAMPUS, or a designee, and is a thorough review of the case. The formal review determination shall be based on the information upon which the initial determination or reconsideration determination was based, and any additional information the appealing party may submit or OCHAMPUS may obtain.

3. Timeliness of formal review determination. The Chief, Appeals and Hearings, OCHAMPUS, or a designee, normally shall issue the formal review determination no later than 90 days from the date of receipt of the request for formal review by the OCHAMPUS.

4. Notice of formal review determination. The Chief, Appeals and Hearings, OCHAMPUS, or a designee, shall issue a written notice of the formal review determination to the appealing party at his or her last known address. The notice of the formal review determination must contain the following elements:

a. A statement of the issue or issues under appeal.

b. The provisions of law, regulation, policies, and guidelines that apply to the issue or issues under appeal.

c. A discussion of the original and additional information that is relevant to the issue or issues under appeal.

d. Whether the formal review upholds the prior determination or determinations or reverses the prior determination or determinations in whole or in part and the rationale for the action.

e. A statement of the right to request a hearing in any case when the formal review determination is less than fully favorable, the issue is appealable, and the amount in dispute is \$300 or more.

5. Effect of formal review determination. The formal review determination is final if one or more of the following exist:

- a. The issue is not appealable. (See subsection A.6., above.)
- b. The amount in dispute is less than \$300. (See subsection A.7., above.)
- c. Appeal rights have been offered but a request for hearing is not received by OCHAMPUS within 60 days of the date of the notice of the formal review determination.

D. HEARING

Any party to the initial determination may request a hearing if the party is dissatisfied with the formal review determination and the formal review determination is not final under the provisions of subsection C.5., above, or the initial determination involves the sanctioning of a provider under Chapter 9 of this Regulation and involves an appealable issue.

1. Requesting a hearing

a. Written request required. The request shall be in writing, state the specific matter in dispute, include a copy of the appropriate initial determination or formal review determination being appealed, and include any additional information or documents not submitted previously.

b. Where to file. The request shall be submitted to the Chief, Appeals and Hearings, OCHAMPUS, Aurora, Colorado 80045-6900.

c. Allowed time to file. The request shall be mailed within 60 days after the date of the notice of the initial determination or formal review determination being appealed.

d. Official filing date. A request for hearing shall be deemed filed on the date it is mailed and postmarked. If a request for hearing does not have a postmark, it shall be deemed filed on the date received by OCHAMPUS.

2. Hearing process. A hearing is an administrative proceeding in which facts relevant to the appealable issue(s) in the case are presented and evaluated in relation to applicable law, regulation, policies, and guidelines in effect at the time the care in dispute was provided or requested; at the time of the initial determination, formal review determination, or hearing decision involving a provider request for approval under CHAMPUS as an authorized provider; or at the time of the act or event which is the basis for the imposition of sanctions under this Regulation. A hearing, except for an appeal involving a provider sanction, generally shall be conducted as a nonadversary, administrative proceeding. However, an authorized party to any hearing, including CHAMPUS, may submit additional evidence or testimony relevant to the appealable issue(s) and may appoint a representative, including legal counsel, to participate in the hearing process.

3. Timeliness of hearing

a. Except as otherwise provided in this chapter, within 60 days following receipt of a request for hearing, the Director, OCHAMPUS, or a designee, normally will appoint a hearing officer to hear the appeal. Copies of all records in the possession of OCHAMPUS that are pertinent to the matter to be heard or that formed the basis of the formal review determination shall be provided to the hearing officer and, upon request, to the appealing party.

b. The hearing officer, except as otherwise provided in this chapter, normally shall have 60 days from the date of written notice of assignment to review the file, schedule and hold the hearing, and issue a recommended decision to the Director, OCHAMPUS, or designee.

c. The Director, OCHAMPUS, or designee, may delay the case assignment to the hearing officer if additional information is needed that cannot be obtained and included in the record within the time period specified above. The appealing party will be notified in writing of the delay resulting from the request for additional information. The Director, OCHAMPUS, or a designee, in such circumstances, will assign the case to a hearing officer within 30 days of receipt of all such additional information, or within 60 days of receipt of the request for hearing, whichever shall occur last.

d. The hearing officer may delay submitting the recommended decision if, at the close of the hearing, any party to the hearing requests that the record remain open for submission of additional information. In such circumstances, the hearing officer will have 30 days following receipt of all such additional information including comments from the other parties to the hearing concerning the additional information to submit the recommended decision to the Director, OCHAMPUS, or a designee.

4. Representation at a hearing. Any party to the hearing may appoint a representative to act on behalf of the party at the hearing, unless such person currently is disqualified or suspended from acting in another Federal administrative proceeding, or unless otherwise prohibited by law, this Regulation, or any other DoD regulation (see paragraph A.2.b., above). A hearing officer may refuse to allow any person to represent a party at the hearing when such person engages in unethical, disruptive, or contemptuous conduct, or intentionally fails to comply with proper instructions or requests of the hearing officer, or the provisions of this Regulation. The representative shall have the same authority as the appealing party and notice given to the representative shall constitute notice required to be given to the appealing party.

5. Consolidation of proceedings. The Director, OCHAMPUS, or a designee, may consolidate any number of proceedings for hearing when the facts and circumstances are similar and no substantial right of an appealing party will be prejudiced.

6. Authority of the hearing officer. The hearing officer in exercising the authority to conduct a hearing under this Regulation will be bound by 10 U.S.C., Chapter 55 (reference (a)), and this Regulation. The hearing officer in addressing substantive, appealable issues shall be bound by policy manuals, instructions, procedures, and other guidelines issued by the

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ASD(HA), or a designee, or by the Director, OCHAMPUS, or a designee, in effect for the period in which the matter in dispute arose. A hearing officer may not establish or amend policy, procedures, instructions, or guidelines. However, the hearing officer may recommend reconsideration of the policy, procedures, instructions or guidelines by the ASD(HA), or a designee, when the final decision is issued in the case.

7. Disqualification of hearing officer. A hearing officer voluntarily shall disqualify himself or herself and withdraw from any proceeding in which the hearing officer cannot give fair or impartial hearing, or in which there is a conflict of interest. A party to the hearing may request the disqualification of a hearing officer by filing a statement detailing the reasons the party believes that a fair and impartial hearing cannot be given or that a conflict of interest exists. Such request immediately shall be sent by the appealing party or the hearing officer to the Director, OCHAMPUS, or a designee, who shall investigate the allegations and advise the complaining party of the decision in writing. A copy of such decision also shall be mailed to all other parties to the hearing. If the Director, OCHAMPUS, or a designee, reassigns the case to another hearing officer, no investigation shall be required.

8. Notice and scheduling of hearing. The hearing officer shall issue by certified mail, when practicable, a written notice to the parties to the hearing of the time and place for the hearing. Such notice shall be mailed at least 15 days before the scheduled date of the hearing. The notice shall contain sufficient information about the hearing procedure, including the party's right to representation, to allow for effective preparation. The notice also shall advise the appealing party of the right to request a copy of the record before the hearing. Additionally, the notice shall advise the appealing party of his or her responsibility to furnish the hearing officer, no later than 7 days before the scheduled date of the hearing, a list of all witnesses who will testify and a copy of all additional information to be presented at the hearing. The time and place of the hearing shall be determined by the hearing officer, who shall select a reasonable time and location mutually convenient to the appealing party and OCHAMPUS.

9. Dismissal of request for hearing

a. By application of appealing party. A request for hearing may be dismissed by the Director, OCHAMPUS, or a designee, at any time before to the mailing of the final decision, upon the application of the appealing party. A request for dismissal must be in writing and filed with the Chief, Appeals and Hearings, OCHAMPUS, or the hearing officer. When dismissal is requested, the formal review determination in the case shall be deemed final, unless the dismissal is vacated in accordance with paragraph D.9.e., below.

b. By stipulation of the parties to the hearing. A request for a hearing may be dismissed by the Director, OCHAMPUS, or a designee, at any time before to the mailing of notice of the final decision under a stipulation agreement between the appealing party and OCHAMPUS. When dismissal is entered under a stipulation, the formal review decision shall be deemed final, unless the dismissal is vacated in accordance with paragraph D.9.e., below.

c. By abandonment. The Director, OCHAMPUS, or a designee, may dismiss a request for hearing upon abandonment by the appealing party.

(1) An appealing party shall be deemed to have abandoned a request for hearing, other than when personal appearance is waived in accordance with paragraph D.11.1., below, if neither the appealing party nor an appointed representative appears at the time and place fixed for the hearing and if, within 10 days after the mailing of a notice by certified mail to the appealing party by the hearing officer to show cause, such party does not show good and sufficient cause for such failure to appear and failure to notify the hearing officer before the time fixed for hearing that an appearance could not be made.

(2) An appealing party shall be deemed to have abandoned a request for hearing if, before assignment of the case to the hearing officer, OCHAMPUS is unable to locate either the appealing party or an appointed representative.

(3) An appealing party shall be deemed to have abandoned a request for hearing if the appealing party fails to prosecute the appeal. Failure to prosecute the appeal includes, but is not limited to, an appealing party's failure to provide information reasonably requested by OCHAMPUS or the hearing officer for consideration in the appeal.

(4) If the Director, OCHAMPUS, or a designee, dismisses the request for hearing because of abandonment, the formal review determination in the case shall be deemed to be final, unless the dismissal is vacated in accordance with paragraph D.9.e., below.

d. For cause. The Director, OCHAMPUS, or a designee, may dismiss for cause a request for hearing either entirely or as to any stated issue. If the Director, OCHAMPUS, or a designee, dismisses a hearing request for cause, the formal review determination in the case shall be deemed to be final, unless the dismissal is vacated in accordance with paragraph D.9.e., below. A dismissal for cause may be issued under any of the following circumstances:

(1) When the appealing party requesting the hearing is not a proper party under paragraph A.2.a., above, or does not otherwise have a right to participate in a hearing.

(2) When the appealing party who filed the hearing request dies, and there is no information before the Director, OCHAMPUS, or a designee, showing that a party to the initial determination who is not an appealing party may be prejudiced by the formal review determination.

(3) When the issue is not appealable (see subsection A.6., above).

(4) When the amount in dispute is less than \$300 (see subsection A.7., above).

(5) When all appealable issues have been resolved in favor of the appealing party.

e. Vacation of dismissal. Dismissal of a request for hearing may be vacated by the Director, OCHAMPUS, or a designee, upon written request of the appealing party, if the request is received within 6 months of the date of the notice of dismissal mailed to the last known address of the party requesting the hearing.

10. Preparation for hearing

a. Prehearing statement of contentions. The hearing officer may on reasonable notice require a party to the hearing to submit a written statement of contentions and reasons. The written statement shall be provided to all parties to the hearing before the hearing takes place.

b. Discovery. Upon the written request of a party to the initial determination (including OCHAMPUS) and for good cause shown, the hearing officer will allow that party to inspect and copy all documents, unless privileged, relevant to issues in the proceeding that are in the possession or control of the other party participating in the appeal. The written request shall state clearly what information and documents are required for inspection and the relevance of the documents to the issues in the proceeding. Depositions, interrogatories, requests for admissions, and other forms of prehearing discovery are generally not authorized and the Department of Defense does not have subpoena authority for purposes of administrative hearings under this chapter. If the hearing officer finds that good cause exists for taking a deposition or interrogatory, the expense shall be assessed to the requesting party, with copies furnished to the hearing officer and the other party or parties to the hearing.

c. Witnesses and evidence. All parties to a hearing are responsible for producing, at each party's expense, meaning without reimbursement of payment by CHAMPUS, witnesses and other evidence in their own behalf, and for furnishing copies of any such documentary evidence to the hearing officer and other party or parties to the hearing. The Department of Defense is not authorized to subpoena witnesses or records. The hearing officer may issue invitations and requests to individuals to appear and testify without cost to the Government, so that the full facts in the case may be presented.

11. Conduct of hearing

a. Right to open hearing. Because of the personal nature of the matters to be considered, hearings normally shall be closed to the public. However, the appealing party may request an open hearing. If this occurs, the hearing shall be open except when protection of other legitimate Government purposes dictates closing certain portions of the hearing.

b. Right to examine parties to the hearing and their witnesses. Each party to the hearing shall have the right to produce and examine witnesses, to introduce exhibits, to question opposing witnesses on any matter relevant to the issue even though the matter was not covered in the direct examination, to impeach any witness regardless of which party to the

hearing first called the witness to testify, and to rebut any evidence presented. Except for those witnesses employed by OCHAMPUS at the time of the hearing, or records in the possession of OCHAMPUS, a party to a hearing shall be responsible, that is to say no payment or reimbursement shall be made by CHAMPUS for the cost or fee associated with producing witnesses or other evidence in the party's own behalf, or for furnishing copies of documentary evidence to the hearing officer and other party or parties to the hearing.

c. Taking of evidence. The hearing officer shall control the taking of evidence in a manner best suited to ascertain the facts and safeguard the rights of the parties to the hearing. Before taking evidence, the hearing officer shall identify and state the issues in dispute on the record and the order in which evidence will be received.

d. Questioning and admission of evidence. A hearing officer may question any witness and shall admit any relevant evidence. Evidence that is irrelevant or unduly repetitious shall be excluded.

e. Relevant evidence. Any relevant evidence shall be admitted, unless unduly repetitious, if it is the type of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule that might make improper the admission of such evidence over objection in civil or criminal actions.

f. CHAMPUS determination first. The basis of the CHAMPUS determinations shall be presented to the hearing officer first. The appealing party shall then be given the opportunity to establish affirmatively why this determination is held to be in error.

g. Testimony. Testimony shall be taken only on oath, affirmation, or penalty of perjury.

h. Oral argument and briefs. At the request of any party to the hearing made before the close of the hearing, the hearing officer shall grant oral argument. If written argument is requested, it shall be granted, and the parties to the hearing shall be advised as to the time and manner within which such argument is to be filed. The hearing officer may require any party to the hearing to submit written memoranda pertaining to any or all issues raised in the hearing.

i. Continuance of hearing. A hearing officer may continue a hearing to another time or place on his or her own motion or, upon showing of good cause, at the request of any party. Written notice of the time and place of the continued hearing, except as otherwise provided here, shall be in accordance with this Regulation. When a continuance is ordered during a hearing, oral notice of the time and place of the continued hearing may be given to each party to the hearing who is present at the hearing.

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j. Continuance for additional evidence. If the hearing officer determines, after a hearing has begun, that additional evidence is necessary for the proper determination of the case, the following procedures may be invoked:

(1) Continue hearing. The hearing may be continued to a later date in accordance with paragraph D.11.i., above.

(2) Closed hearing. The hearing may be closed, but the record held open in order to permit the introduction of additional evidence. Any evidence submitted after the close of the hearing shall be made available to all parties to the hearing, and all parties to the hearing shall have the opportunity for comment. The hearing officer may reopen the hearing if any portion of the additional evidence makes further hearing desirable. Notice thereof shall be given in accordance with subsection D.8., above.

k. Transcript of hearing. A verbatim taped record of the hearing shall be made and shall become a permanent part of the record. Upon request, the appealing party shall be furnished a duplicate copy of the tape. A typed transcript of the testimony will be made only when determined to be necessary by OCHAMPUS. If a typed transcript is made, the appealing party shall be furnished a copy without charge. Corrections shall be allowed in the typed transcript by the hearing officer solely for the purpose of conforming the transcript to the actual testimony.

1. Waiver of right to appear and present evidence. If all parties waive their right to appear before the hearing officer for presenting evidence and contentions personally or by representation, it will not be necessary for the hearing officer to give notice of, or to conduct a formal hearing. A waiver of the right to appear must be in writing and filed with the hearing officer or the Chief, Appeals and Hearings, OCHAMPUS. Such waiver may be withdrawn by the party by written notice received by the hearing officer or Chief, Appeals and Hearings, no later than 7 days before the scheduled hearing or the mailing of notice of the final decision, whichever occurs first. For purposes of this chapter, failure of a party to appear personally or by representation after filing written notice of waiver, will not be cause for finding of abandonment and the hearing officer shall make the recommended decision on the basis of all evidence of record.

12. Recommended decision. At the conclusion of the hearing and after the record has been closed, the matter shall be taken under consideration by the hearing officer. Within the time frames previously set forth in this chapter, the hearing officer shall submit to the Director, OCHAMPUS, or a designee, a written recommended decision containing a statement of findings and a statement of reasons based on the evidence adduced at the hearing and otherwise included in the hearing record.

a. Statement of findings. A statement of findings is a clear and concise statement of fact evidenced in the record or conclusions that readily can be deduced from the evidence of record. Each finding must be supported by substantial evidence that is defined as such evidence as a reasonable mind can accept as adequate to support a conclusion.

b. Statement of reasons. A reason is a clear and concise statement of law, regulation, policies, or guidelines relating to the statement of findings that provides the basis for the recommended decision.

E. FINAL DECISION

1. Director, OCHAMPUS. The recommended decision shall be reviewed by the Director, OCHAMPUS, or a designee, who shall adopt or reject the recommended decision or refer the recommended decision for review by the Assistant Secretary of Defense (Health Affairs). The Director, OCHAMPUS, or designee, normally will take action with regard to the recommended decision within 90 days of receipt of the recommended decision or receipt of the revised recommended decision following a remand order to the Hearing Officer.

a. Final action. If the Director, OCHAMPUS, or a designee, concurs in the recommended decision, no further agency action is required and the recommended decision, as adopted by the Director, OCHAMPUS, is the final agency decision in the appeal. In the case of rejection, the Director, OCHAMPUS, or a designee, shall state the reason for disagreement with the recommended decision and the underlying facts supporting such disagreement. In these circumstances, the Director, OCHAMPUS, or a designee, may have a final decision prepared based on the record, or may remand the matter to the Hearing Officer for appropriate action. In the latter instance, the Hearing Officer shall take appropriate action and submit a new recommended decision within 60 days of receipt of the remand order. The decision by the Director, OCHAMPUS, or a designee, concerning a case arising under the procedures of this Chapter 10, shall be the final agency decision and the final decision shall be sent by certified mail to the appealing party or parties. A final agency decision under this subsection E.1. will not be relied on, used, or cited as precedent by the Department of Defense in the administration of CHAMPUS.

b. Referral for review by ASD(HA). The Director, OCHAMPUS, or a designee, may refer a hearing case to the Assistant Secretary of Defense (Health Affairs) when the hearing involves the resolution of CHAMPUS policy and issuance of a final decision which may be relied on, used, or cited as precedent in the administration of CHAMPUS. In such a circumstance, the Director, OCHAMPUS, or a designee, shall forward the recommended decision, together with the recommendation of the Director, OCHAMPUS, or a designee, regarding disposition of the hearing case.

2. ASD(HA). The ASD(HA), or a designee, after reviewing a case arising under the procedures of this Chapter 10 may issue a final decision based on the record in the hearing case or remand the case to the Director, OCHAMPUS, or a designee, for appropriate action. A decision issued by the ASD(HA), or a designee, shall be the final agency decision in the appeal and a copy of the final decision shall be sent by certified mail to the appealing party or parties. A final decision of the ASD(HA), or a designee, issued under this subsection E.2. may be relied on, used, or cited as precedent in the administration of CHAMPUS.

CHAPTER 11
OVERPAYMENTS RECOVERY

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CHAPTER 11
OVERPAYMENTS RECOVERY

A. GENERAL

Actions to recover overpayments arise when the government has a right to recover money or property from an individual, partnership, association, corporation, governmental body or other legal entity, foreign or domestic, except an instrumentality of the United States because of an erroneous payment of benefits under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). A claim against several joint debtors arising from a single incident or transaction is considered to be one claim. It is the purpose of this chapter to prescribe procedures for investigation, determination, assertion, collection, compromise, waiver and termination of claims in favor of the United States for erroneous benefits payments arising out of administration of CHAMPUS.

B. AUTHORITY

1. Federal statutory authority. The Federal Claims Collection Act (reference (ii)) provides the basic authority under which claims may be asserted pursuant to this chapter. The Federal Claims Collection Act is a statute enacted to avoid unnecessary litigation. The Federal Claims Collection Act was substantially amended by the Debt Collection Act of 1982, Public Law 97-365, enacted on October 25, 1982. The Federal Claims Collection Act is implemented by joint regulations issued by the Department of Justice and the General Accounting Office, 4 CFR Parts 101-105. Thereunder, the heads of federal agencies or their designees are required to attempt collection of all claims of the United States for money or property arising out of the activities of their respective agencies. These officials may, with respect to claims that do not exceed \$20,000, exclusive of interest, and in conformity with the standards promulgated in the joint regulations, compromise, suspend, or terminate collection action on such claims.

2. Other authority. Occasionally, federal claims may arise which are grounded, at least in part, in authority other than the federal statute referenced above. These include, but are not limited to, claims arising under:

- a. State worker's compensation laws.
- b. State hospital lien laws.
- c. State no-fault automobile statutes.
- d. Contract rights under terms of insurance policies.

C. POLICY

The governmental policy of avoiding unnecessary litigation in the

collection of claims by the United States for money or property necessitates aggressive agency collection action. The Director, OCHAMPUS, or a designee, will insure that CHAMPUS claims asserting personnel are adequately supported to take timely and effective action. Claims arising out of any incident which has or probably will generate a claim in favor of the government will not be compromised nor will collection action be terminated by any person not authorized to take final action on the government's claim. By the Act of July 18, 1966 (28 U.S.C. 2415-2418), Congress established a statute of limitation applicable to the government in areas where previously neither limitations nor laches were available as a defense. Claims falling within the provisions of this statute will be processed expeditiously to the Department of Justice or the General Accounting Office, as appropriate, without attempting administrative collection action if such action cannot be accomplished in sufficient time to preclude the running of the statute of limitations.

D. APPEALABILITY

This chapter describes the procedures to be followed in the recovery and collection of federal claims in favor of the United States arising from the operation of the CHAMPUS. Actions taken under this chapter are not initial determinations for the purpose of the appeal procedures of Chapter 10 of this Regulation. However, the proper exercise of the right to appeal benefit or provider status determinations under the procedures set forth in Chapter 10 may affect the processing of federal claims arising under this chapter. Those appeal procedures afford a CHAMPUS beneficiary or participating provider an opportunity for administrative appellate review in cases in which benefits have been denied and in which there is a significant factual dispute. For example, a fiscal intermediary may erroneously make payment for services which are excluded as CHAMPUS benefits because they are determined to be not medically necessary. In that event recoupment action will be initiated by the fiscal intermediary at the same time the fiscal intermediary will offer an administrative appeal as provided in Chapter 10 of this Regulation on the medical necessity issue raised by the adverse benefit determination. The recoupment action and the administrative appeal are separate actions. However, in an appropriate case, the pendency of the appeal may provide a basis for the suspension of collection in the recoupment. Obviously, if the appeal is resolved entirely in favor of the appealing party, that would provide a basis for the termination of collection action in the recoupment case.

E. DELEGATION

Subject to the limitations imposed by law or contained in this chapter, the authority to assert, settle, compromise or to suspend or terminate collection action on claims arising under the Federal Claims Collection Act (reference (ii)) has been delegated to the Director, OCHAMPUS, or a designee.

F. RECOUPMENT OF ERRONEOUS PAYMENTS

1. Erroneous payments. Erroneous payments are expenditures of

government funds which are not authorized by law or the Regulation. Examples which are sometimes encountered in the administration of the CHAMPUS include mathematical errors, payment for care provided to an ineligible person, payment for care which is not an authorized benefit, payment for duplicate claims, inaccurate application of the deductible or co-payment, or payment for services which were not medically necessary. Claims in favor of the government arising as the result of the filing of false CHAMPUS claims or other fraud fall under the direct cognizance of the Department of Justice. Consequently, the procedures in this chapter apply to such claims only when specifically authorized or directed by the Department of Justice. (See 32 CFR 101.3.)

2. Scope

a. General. This section F. and the sections following contain requirements and procedures for the assertion, collection or compromise of, and the suspension or termination of collection action on claims for erroneous payments against a sponsor, beneficiary, provider, physician or other supplier of services under the CHAMPUS. These provisions are adopted pursuant to the Federal Claims Collection Act (31 U.S.C. 3701 et seq., as amended by the Debt Collection Act of 1982, Public Law 97-365), which requires each agency of the U.S. Government (pursuant to regulations jointly promulgated by the Attorney General and the Comptroller General) to attempt collection of federal claims in favor of the United States arising out of the activities of the agency, and 5 U.S.C. 5514, which provides for installment deduction for indebtedness to the United States, implemented by regulations issued by the Office of Personnel Management, 5 CFR 550, and the Department of Defense, 32 CFR 90. This section also includes government-wide collections by salary offset under 5 U.S.C. 5514.

b. Debtor defined. As used herein, "debtor" means a sponsor, beneficiary, provider, physician, other supplier of services or supplies, or any other person who has for any reason been erroneously paid under the CHAMPUS. It includes an individual, partnership, corporation, professional corporation or association, estate, trust or any other legal entity.

c. Delinquency defined. As used herein, a debt is considered "delinquent" if it has not been paid by the date specified in the initial demand for payment (that is, the initial written notification) or applicable contractual agreement, unless other satisfactory payment arrangements have been made by that date. A debt is also considered delinquent if at any time after entering into a repayment agreement, the debtor fails to satisfy any obligations under that agreement.

3. Other health insurance claims. Claims arising from erroneous CHAMPUS payments in situations where the beneficiary has entitlement to insurance, medical service, health and medical plan, or other government program, except in the case of a plan administered under Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), through employment, by law, through membership in an organization, or as a student, or through the purchase of a private insurance or health plan, shall be recouped under one of the following procedures:

a. Where the other health insurance plan has not already made benefit payments to the beneficiary or provider, a claim for direct reimbursement will be asserted against the plan, pursuant to the fiscal intermediary's coordination of benefit procedures.

b. If the other health insurance plan has made its benefit payment prior to receiving the CHAMPUS request for reimbursement, the recoupment procedures set forth in this section will be followed.

4. Claims denials due to clarification or change. In those instances where claim review results in the denial of benefits previously provided but now denied due to a change, clarification or interpretation of the public law or this Regulation, no recoupment action need be taken to recover funds expended prior to the effective date of such change, clarification, or interpretation.

5. Good faith payment

a. The Department of Defense, through the Defense Enrollment Eligibility Reporting System (DEERS), is responsible for establishing and maintaining a file listing persons eligible to receive benefits under CHAMPUS. However, it is the responsibility of the Uniformed Services to provide eligible CHAMPUS beneficiaries with accurate and appropriate means of identification. When sources of civilian medical care exercise reasonable care and precaution in identifying persons claiming to be eligible CHAMPUS beneficiaries and furnish otherwise covered services and supplies to such persons in good faith, CHAMPUS benefits may be paid subject to prior approval by the Director, OCHAMPUS, or a designee, notwithstanding the fact that the person receiving the services and supplies is subsequently determined to be ineligible for benefits. Good faith payments will not be authorized for services and supplies provided by a civilian source of medical care as the result of its own careless identification procedures.

b. When it is determined that a person was not a CHAMPUS beneficiary, the CHAMPUS fiscal intermediary and the civilian source of medical care are expected to make all reasonable efforts to obtain payment or recoup the amount of the good faith payment from the person who erroneously claimed to be a CHAMPUS beneficiary. Recoupments of good faith payments initiated by the CHAMPUS fiscal intermediary will be processed pursuant to the provisions of this section.

6. Recoupment procedures

a. Initial action. When an erroneous payment is discovered, the CHAMPUS fiscal intermediary normally will be required to take the initial action to effect recoupment. Such action will be in accordance with the provisions of this regulation and the fiscal intermediary's CHAMPUS contract and will include demands for refund or an offset against any other CHAMPUS payment becoming due the debtor. When the efforts of the CHAMPUS fiscal intermediary to effect recoupment are not successful within a reasonable time, recoupment cases will be referred to the General Counsel, OCHAMPUS, for

further action in accordance with the provisions of this section. All requests to debtors for refund or notices of intent to offset shall be in writing.

b. Demand for payment. The CHAMPUS fiscal intermediary and OCHAMPUS normally shall make a total of at least three progressively stronger written demands upon the debtor in terms which inform the debtor of the consequences of his or her failure to cooperate. The initial written demand shall inform the debtor of the basis for and the amount of the indebtedness. The initial written demand shall also inform the debtor of the following: the debtor's right to inspect and copy all records pertaining to the debt; his or her right to request an administrative review by the fiscal intermediary; that interest on the debt at the current rate as determined by the Director, OCHAMPUS, or a designee, will begin to accrue on the date of the initial demand notification; that such interest shall be waived on the debt, or any portion thereof, which is paid within 30 days of the date of the initial demand notification; that payment of the indebtedness is due within 30 days of the date of the initial demand notification; and that administrative costs and penalties will be charged pursuant to 4 CFR 102.13. The debtor also shall be informed that collection by offset against current or subsequent claims may be taken. All debtors will be offered an opportunity to enter into a written agreement to repay the indebtedness. The fiscal intermediary demand letters must be dated the same day as they are mailed. Two written demands, at 30-day intervals, normally will be made by the CHAMPUS fiscal intermediary unless a response to the first demand indicates that further demand would be futile or unless prompt suit or attachment is required in anticipation of the departure of the debtor, of his removal or transfer of assets, or the running of the statute of limitations. There should be no undue time lag in responding to any communication received from the debtor. Responses should be made within 30 days whenever feasible. If these initial efforts at collection are not productive or if immediate legal action on the claim appears necessary, the claim either will be referred promptly by the CHAMPUS fiscal intermediary to the General Counsel, OCHAMPUS, or the CHAMPUS fiscal intermediary will prepare a final notice informing the debtor that the debt is to be offset in whole or in part. When a case is referred to OCHAMPUS, the Office of General Counsel will normally prepare a third written demand unless from the record such demand appears futile or otherwise inappropriate.

c. Collection by administrative offset. Collections by offset will be undertaken administratively on claims which are liquidated or certain in amount in every instance in which this is feasible. No collection by offset may be undertaken unless a demand for payment containing all of the procedural safeguards described in paragraph F.6.b. above has been sent to the debtor. The determinations of indebtedness made for recoupment of erroneous CHAMPUS payments rarely involve issues of credibility or veracity. Erroneous CHAMPUS payments most frequently arise from claims submitted by individuals ineligible for CHAMPUS benefits; from claims submitted for services or supplies not covered by CHAMPUS; from claims in which there have been other insurance payments which reduce the CHAMPUS liability and from claims from participating providers in which payment is initially erroneously made to the beneficiary. While these recoupment claims normally involve the resolution of factual

questions, these resolutions nearly always require only reference to the documentary evidence compiled in the investigation and processing of the claim. The appeals system described in Chapter 10 of this Regulation affords a CHAMPUS beneficiary or participating provider an opportunity for an administrative appellate review, including, under certain circumstances, the right to oral hearing before a hearing officer. Further, there is no statutory provision for the waiver of indebtedness arising from erroneous CHAMPUS payments, other than the provisions of the Federal Claims Collection Act (reference (ii)) which allow for the compromise of claims or the termination of collection action under certain circumstances specified in section G. of this chapter. Consequently, the pre-offset oral hearing requirements of the Federal Claims Collection Standards (4 CFR 102.3) do not apply to the recoupment of erroneous CHAMPUS payments. CHAMPUS fiscal intermediaries may take administrative action to offset erroneous payments against other current CHAMPUS payments owing a debtor. Payments on the claims of a debtor pending at or filed subsequent to the time collection action is initiated should be suspended pending the outcome of the collection action so that these funds will be available for offset. All or any part of a debt may be offset depending upon the amount available for offset. Only the cases in which no possibility of offset arises within 60 days of the initiation of collection action and on which other collection efforts have been unsuccessful or in which the debtor seeks relief from the indebtedness will be referred to the General Counsel, OCHAMPUS, by the CHAMPUS fiscal intermediary. Offset, under the provisions of 31 U.S.C. 3716, is not to be used with respect to debts owed by any state or local government. Any requests for offset that are received from other agencies shall be forwarded to the General Counsel, OCHAMPUS, for processing, as will orders for garnishment issued by courts of competent jurisdiction.

d. Collection of installments. CHAMPUS recoupment claims should be collected in one lump sum whenever possible. However, if the debtor is financially unable to pay the debt in one lump sum, payment may be accepted in regular installments by the CHAMPUS fiscal intermediary or the General Counsel, OCHAMPUS. Installment payments normally will be required on at least a monthly basis and their size will bear a reasonable relation to the size of the debt and the debtor's ability to pay. A CHAMPUS fiscal intermediary should not enter into installment agreements which extend beyond 24 months. OCHAMPUS installment agreements normally should liquidate the government's claim within 3 years. Installment payments of less than \$50 per month normally will be accepted only if justifiable on grounds of financial hardship or some other reasonable cause. Any installment agreement with a debtor in which the total amount of the deferred installments will exceed \$750 should normally include an executed promissory note.

e. Interest, penalties, and administrative costs. Interest shall be charged on CHAMPUS recoupment debts and debts collected in installments in accordance with 4 CFR 102.13 and instructions issued by the Director, OCHAMPUS, or a designee. Interest shall accrue from the date on which the initial demand is mailed to the debtor. The rate of interest assessed shall be the rate of the current value of funds to the United States Treasury (that is, the Treasury tax and loan account rate). The rate of interest, as

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initially assessed, shall remain fixed for the duration of the indebtedness, except that where the debtor has defaulted on a repayment agreement and seeks to enter into a new agreement, a new interest rate may be set which reflects the current value of funds to the Treasury at the time the new agreement is executed. The collection of interest on the debt or any portion of the debt, which is paid within 30 days after the date on which interest began to accrue, shall be waived. The agency may extend this 30-day period, on a case-by-case basis, if it reasonably determines that such action is appropriate. Also, the collection of interest, penalties, and administrative costs may be waived in whole or in part as a part of the compromise of a debt as provided in section G. of this chapter. In addition, the Director, OCHAMPUS, or a designee, may waive in whole or in part, the collection of interest, penalties, or administrative costs assessed herein, if he or she determines that collection of these charges would be against equity and good conscience or not in the best interests of the United States. Some situations in which such a waiver may be appropriate include:

(1) Waiver of interest consistent with 4 CFR 104.2(c)(2) in connection with a suspension of collection action pending a CHAMPUS appeal under Chapter 10 of this Regulation where there is a substantial issue of fact in dispute.

(2) Waiver of interest where the original debt arose through no fault or lack of good faith on the part of the debtor and the collection of interest would impose a financial hardship or burden on the debtor. Some examples in which such a waiver may be appropriate include: a debt arising when a CHAMPUS beneficiary, who is unaware of the loss of eligibility for CHAMPUS because he or she has become eligible for Medicare, continues to file and be paid for CHAMPUS claims, resulting in erroneous CHAMPUS payments; a debt arising when a CHAMPUS beneficiary in good faith files and is paid a CHAMPUS claim for medical services or supplies which are later determined not to be benefits of CHAMPUS; and a debt arising when a CHAMPUS beneficiary is overpaid as the result of a calculation error on the part of a fiscal intermediary or OCHAMPUS.

(3) Waiver of interest where there has been an agreement to repay a debt in installments, there is no indication of fault or lack of good faith on the part of the debtor, and the amount of interest is so large in relation to the size of the installments that the debtor can reasonably afford to pay, that it is likely the debt will never be repaid in full.

When a debt is paid in installments, the installment payments first will be applied to the payment of outstanding penalty and administrative cost charges, second to accrued interest and then to principal.

Administrative costs incurred as the result of a debt becoming delinquent (as defined in paragraph F.2.c. of this chapter) shall be assessed against a debtor. These administrative costs represent the additional costs incurred in processing and handling the debt because it became delinquent. The calculation of administrative costs should be based upon cost analysis establishing an average of actual additional costs incurred in processing and

handling claims against other debtors in similar stages of delinquency. A penalty charge, not exceeding six percent a year shall be assessed on any portion of a debt that is delinquent for more than 90 days. This charge, which need not be calculated until the 91st day of delinquency, shall accrue from the date that the debt became delinquent.

f. Referral to other federal agencies for administrative offset.
As appropriate and in accordance with 4 CFR 1023, agencies will be requested to initiate administrative offset to collect CHAMPUS debts. When a debtor is employed by the U.S. Government, or is a member or retired member of the Uniformed Service, and collection by offset against other CHAMPUS payments due the debtor cannot be accomplished, and there have been no positive responses to a demand for payment within 60 days, the Director, OCHAMPUS, or a designee, may contact the agency holding funds payable to the debtor for payment by allotment or otherwise by salary offset from current disposable pay in accordance with 37 U.S.C. 1007 or 5 U.S.C. 5514 as implemented by 32 CFR 90 and 5 CFR 550. Where applicable, the request for recovery of erroneous CHAMPUS payments shall be submitted to the debtor's paying agency in accordance with 5 CFR 550.1106. Before contacting the paying agency, the Director, OCHAMPUS, or a designee, will provide the debtor written notification of the agency's intent to collect the debt by means of salary offset, authorized by 5 U.S.C. 5514. The notification will include, as a minimum:

(1) The agency's determination that a debt is owed, including the origin, nature, and the amount of the debt;

(2) The date by which payment is to be made, which will normally be 30 days from the date the demand letter is mailed;

(3) The amount, frequency, proposed beginning date and duration of the intended deductions, which will be determined in accordance with the provisions of 5 CFR 550.1104 or 32 CFR 90, as appropriate. Ordinarily, the size of installment deductions must bear a reasonable relationship to the size of the debt and the employee's ability to pay (4 CFR 102.11). However, the amount deducted for any period must not exceed 15 percent of the disposable pay from which the deduction is made unless the debtor has agreed in writing to the deduction of a greater amount. Debts must be collected in one lump-sum whenever possible. However, if the employee is financially unable to pay in one lump-sum, or the amount of the debt exceeds 15 percent of current disposable pay for an officially established pay interval, collection must be made in installments. Such installment deductions must be made to effect collection within the period of anticipated active duty or employment. If the debtor retires or resigns or if his or her employment or period of active duty ends before collection of the debt is completed, offset from subsequent payments of any kind due the employee from the paying agency as of the date of separation shall be made to the extent necessary to liquidate the debt pursuant to 31 U.S.C. 3716 as implemented by 5 CFR 550 and 32 CFR 90. If possible, the installment payments should be sufficient in size and frequency to liquidate the government's claim in not more than 3 years. Installment payments of less than \$50 per month should be

accepted only with reasonable justification. An employee's involuntary payment of all or any portion of a debt being collected under 5 U.S.C. 5514 will not be construed as a waiver of any rights the debtor may have under that statute or any other provisions of contract or law, unless there are statutory or contractual provisions to the contrary;

(4) An explanation of interest, penalties, and administrative costs, including a statement that such assessments must be made unless excused in accordance with the Federal Claims Collection Standards;

(5) Advice that the debtor may inspect and copy government records relating to the debt or, if debtor or his or her representative cannot personally inspect the records, to request and receive a copy of such records. Requests for copies of the records relating to the debt shall be made no later than 10 days from the receipt by the debtor of the notice of indebtedness;

(6) An opportunity for a review by the agency of its determination regarding the existence or the amount of the debt, or when a repayment schedule is established other than by written agreement, concerning the terms of the repayment schedule. The debtor shall be advised that a challenge to either the existence of the debt, the amount of the debt, or the repayment schedule, must be made within 30 days of the receipt by the debtor of the notice of indebtedness or within 45 days after receipt of the records relating to the debt, if such records are requested by the debtor. A request for waiver or reconsideration should be accompanied by supporting documents indicating why the debtor believes he is not so indebted, or by a financial affidavit supporting his request for an alternative repayment schedule;

(7) Notice that the timely filing of a petition for review will stay the commencement of collection proceedings;

(8) Notice that a final decision on the review (if one is requested) will be issued at the earliest practical date, but not later than 60 days after the filing of the petition requesting the review unless the employee requests, and the agency grants, a delay in the proceedings;

(9) The opportunity, if it has not been previously provided, to enter into a written agreement to establish a schedule for repayment of the debt in lieu of offset. The agreement will be signed, by both the debtor and the agency's representative and will be kept in the agency's files;

(10) Notice that any knowingly false or frivolous statements, representations, or evidence may subject the debtor to: (a) disciplinary procedures appropriate under Chapter 75 of Title 5 United States Code, 5 CFR 752, or any other applicable statutes or regulations; (b) penalties under the False Claims Act, 31 U.S.C. 3729-3731, or any other applicable authority; or (c) criminal penalties under 18 U.S.C. Sections 286, 287, 1001 and 1002, or any other applicable authority;

(11) Where applicable, notice of the debtor's right to appeal

under Chapter 10 of this Regulation;

(12) That amounts paid on or deducted for the debt which are later waived or found not owed to the United States will promptly be refunded to the debtor. Refunds do not bear interest unless required or permitted by law or contract;

(13) The specific address to which all correspondence regarding the debt shall be directed. Unless otherwise prohibited by law, moneys which are due and payable to a debtor from the Civil Service Retirement and Disability Fund may be administratively offset in reasonable amounts in order to collect in one full payment or a minimal number of payments debts owed to the United States by the debtor. The General Counsel, OCHAMPUS, may forward requests for offset of debts arising from the operation of CHAMPUS to the appropriate officials of the Office of Personnel Management. These requests shall comply with the provisions of 4 CFR 102.4 and 5 CFR 550.

g. Referral to debt collection agencies. Pursuant to the provisions of the Federal Claims Collection Standards (4 CFR 102.6), the Director, OCHAMPUS, or a designee, is authorized to enter into contracts for collection services, including contracts with private collection agencies for the purpose of supplementing and strengthening the collection efforts of the Department of Defense in recouping erroneous CHAMPUS payments. Such contracts will supplement but not replace the basic collection program described herein. The authority to resolve disputes, compromise claims, terminate collection action and initiate legal action may not be delegated in such contracts but will be retained by the Director, OCHAMPUS, or a designee. Individuals or firms that enter into contracts for collection services pursuant to this paragraph are subject to the Privacy Act of 1974, as amended, 5 U.S.C. 552a, federal and state laws and regulations pertaining to debt collection practices, including the Fair Debt Collection Practices Act, 15 U.S.C. 1692. Debt collection contractors shall be required to account strictly for all amounts collected and must agree to provide any data contained in their files relating to paragraphs (a)(1), (2) and (3) of 4 CFR 105.2. Contracts for commercial collection services must comply with 32 CFR 90.

h. Referrals to consumer reporting agencies. The Director, OCHAMPUS, or a designee, is authorized to provide for the reporting of delinquent debts to consumer reporting agencies. Delinquent debts are those which are not paid or for which satisfactory payment arrangements are not made by the due date specified in the initial notification of indebtedness, or those for which the debtor has entered into a written payment agreement and installment payments are past due 30 days or longer. These referrals may be made only after publication of a "routine use" for the disclosures involved as required by the Privacy Act of 1974, as amended, 5 U.S.C. 552a. Procedures developed for such referrals must also insure that an accounting of the disclosures is kept which is available to the debtor; that the consumer reporting agencies are provided with corrections and annotations of disagreements by the debtor; and that reasonable efforts are made to assure that the information to be reported is accurate, complete, timely and

relevant. When requested by a consumer reporting agency, verification of information disclosed will promptly be provided. Once a claim has been reviewed and determined to be valid, a complete explanation of the claim will be given the debtor. When the claim is overdue, the individual will be notified in writing that payment is overdue; that within 60 days, disclosure of the claim shall be made to a consumer reporting agency unless satisfactory payment arrangements are made or unless the debtor requests an administrative review and demonstrates some basis on which the debt is legitimately disputed; and of the specific information to be disclosed to the consumer reporting agency. The information to be disclosed to the consumer reporting agency will be limited to information necessary to establish the identity of the debtor, including name, address and taxpayer identification number; the amount, status and history of the claim; and the agency or program under which the claim arose. Reasonable action will be taken to locate an individual for whom a current address is not available.

i. Use and disclosure of mailing addresses. In attempting to locate a debtor in the collection of a debt under this section, the Director, OCHAMPUS, or a designee, may send a written request to the Secretary of the Treasury, or a designee, for current address information from records of the Internal Revenue Service. These requests will comply with the provisions of 26 U.S.C. 6103(p)(4) and applicable regulations of the Internal Revenue Service. Disclosure of a mailing address so obtained may be made pursuant to 4 CFR 102.18(b) and 31 U.S.C. 3711.

G. COMPROMISE, SUSPENSION, OR TERMINATION OF COLLECTION ACTIONS ARISING UNDER THE FEDERAL CLAIMS COLLECTION ACT

1. Basic considerations. Federal claims against the debtor and in favor of the United States arising out of the administration of the CHAMPUS may be compromised or collection action thereon may be suspended or terminated if:

a. The claim exclusive of interest, penalties and administrative costs, does not exceed \$20,000, and

b. There is no indication of fraud, the filing of a false claim, or misrepresentation on the part of the debtor or any director, partner, manager, or other party having an interest in the claim.

c. After deducting the amount of partial payments or collections, if any, if a claim exceeds \$20,000, exclusive of interest, penalties, and administrative costs, the authority to compromise, suspend, or terminate collection action rests solely with the Department of Justice.

2. Authority. CHAMPUS fiscal intermediaries are not authorized to compromise or to suspend or terminate collection action on federal CHAMPUS claims. Only the Director, OCHAMPUS, or a designee, and Uniformed Service claims officers acting under the provisions of their own regulations, are so authorized.

3. Basis for compromise. A claim may be compromised hereunder if the

government cannot collect the full amount if:

a. The debtor or the estate of a debtor does not have the present or prospective ability to pay the full amount within a reasonable time;

b. The debtor refuses to pay the claim in full and the government is unable to enforce collection of the full amount within a reasonable time by enforced collection proceedings;

c. There is real doubt concerning the government's ability to prove its case in court for the full amount claimed either because of the legal issues involved or a bona fide dispute as to the facts; or

d. The cost of collecting the claim does not justify enforced collection of the full amount.

4. Basis for suspension. Collection action may be suspended for either of the following reasons if future collection action may be sufficiently productive to justify periodic review and action on the claim giving consideration to its size and the amount which may be realized thereon:

a. The debtor cannot be located; or

b. The debtor is unable to make payments on the government's claim or effect a compromise at the time, but the debtor's future prospects justify retention of the claim for periodic review and action and: (1) the applicable statute of limitations has been tolled or started running anew; or (2) future collection action can be effected by offset, notwithstanding the statute of limitations with due regard to the 10-year limitation prescribed by 31 U.S.C. 3716(c)(1); or (3) the debtor agrees to pay interest on the amount of the debt on which collection action will be temporarily suspended, and such temporary suspension is likely to enhance the debtor's ability to fully pay the principal amount of the debt with interest at a later date.

c. Consideration may be given by the Director, OCHAMPUS, or a designee, to suspend collection action pending action on a request for a review of the government's claim against the debtor or pending an administrative review under Chapter 10 of this Regulation of any CHAMPUS claim or claims directly involved in the government's claim against the debtor. Suspension under this paragraph will be based upon appropriate consideration, on a case-by-case basis as to whether: (1) there is a reasonable possibility that the debt (in whole or in part) will be found not owing from the debtor; (2) the government's interest would be protected if suspension were granted by reasonable assurance that the debt would be recovered if the debtor does not prevail; and (3) collection of the debt will cause undue hardship.

5. Basis for termination. Collection action may be terminated for one or more of the following reasons:

a. The United States cannot collect or enforce collection of any

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significant sum from the debtor having due regard to the judicial remedies available to the government, the debtor's future financial prospects and the exemptions available to the debtor under state and federal law;

b. The debtor cannot be located, and either: (1) there is no security remaining to be liquidated, or (2) the applicable statute of limitations has run and the prospects of collecting by offset, notwithstanding the bar of the statute of limitations, are too remote to justify retention of the claim;

c. The cost of further collection action is likely to exceed any recovery;

d. It is determined that the claim is legally without merit; or

e. Evidence necessary to prove the claim cannot be produced or the necessary witnesses are unavailable and efforts to induce voluntary payment are unavailing.

6. Factors considered. In determining whether a claim will be compromised, or collection action terminated or suspended, the responsible CHAMPUS collection authority will consider the following factors:

a. Age and health of the debtor, present and potential income, inheritance prospects, possible concealment or improper transfer of assets and the availability of assets or income which may be realized upon by enforced collection proceedings;

b. Applicability of exemptions available to a debtor under state or federal law;

c. Uncertainty as to the price which collateral or other property may bring at forced sale; or

d. The probability of proving the claim in court, the probability of full or partial recovery, the availability of necessary evidence and related pragmatic considerations.

7. Amount of compromise. The amount acceptable in compromise will be reasonable in relation to the amount that can be recovered by enforced collection proceedings. Consideration shall be given to the following:

a. The exemptions available to the debtor under state and federal law;

b. The time necessary to collect the debt;

c. The litigative probabilities involved; and

d. The administrative and litigative costs of collection where the cost of collecting the claim is a basis for compromise.

8. Payment of compromised claims

a. Time and manner. Compromised claims are to be paid in one lump sum if possible. However, if payment of a compromise is necessary, a legally enforceable compromise agreement must be obtained. Payment of the amount that CHAMPUS has agreed to accept as a compromise in full settlement of a CHAMPUS claim must be made within the time and in the manner prescribed in the compromise agreement. Any such compromised claim is not settled until the full payment of the compromised amount has been made within the time and the manner prescribed. Compromise agreements must provide for the reinstatement of the prior indebtedness, less sums paid thereon, and acceleration of the balance due upon default in the payment of any installment.

b. Failure to pay the compromised amount. Failure of any debtor to make payment as provided in the compromise agreement will have the effect of reinstating the full amount of the original claim, less any amounts paid prior to the default.

9. Effect of compromise, or suspension, or termination of collection action. Pursuant to the Internal Revenue Code, 26 U.S.C. 6041, compromises and terminations of undisputed debts not discharged in a Title 11 bankruptcy case and totaling \$600 or more for the year will be reported to the Internal Revenue Service in the manner prescribed by them for inclusion in the debtor's gross income for that year. Any action taken under section G. of this chapter regarding the compromise of a federal claim, or suspension or termination of collection action on a federal claim is not an initial determination for purpose of the appeal procedures of Chapter 10 of this Regulation.

H. REFERRALS FOR COLLECTION

1. Prompt referral. Federal claims of \$600 or more on which collection action has been taken in accordance with the provisions of this chapter and which cannot be collected or compromised or on which collection action cannot be suspended or terminated, as provided herein, will be promptly referred by the Director, OCHAMPUS, or a designee, to the Department of Justice for litigation in accordance with 4 CFR 105. Such referrals will be made as early as possible consistent with aggressive collection action by CHAMPUS fiscal intermediaries and OCHAMPUS and well within the period for bringing a timely suit against the debtor. Ordinarily referrals will be made within one year of the OCHAMPUS final determination of the fact and the amount of the debt.

2. Report of prior collection actions. The Director, OCHAMPUS, or a designee, will prepare a Claims Collection Litigation Report (CCLR) for each case referred for collection under the provisions of this chapter. The CCLR shall also be used when a claim is referred to the Department of Justice in order to obtain approval of that Department with respect to compromise, suspension, or termination when such approval is required by 4 CFR 103.1(b) and 104.1(b). The CCLR will include, as a minimum, the following:

a. A checklist or brief summary of the actions previously taken to collect or compromise the claim. If any of the required administrative collection actions have been omitted, the reason for its omission must be provided.

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b. The current address of the debtor, or the name and address of the agent for a corporation upon whom service may be made. Reasonable and appropriate steps will be taken to locate missing parties in all cases. Referrals to the Department of Justice for the institution of foreclosure or other proceedings, in which the current address of any party is unknown, will be accompanied by a listing of the prior known addresses of such party and a statement of the steps taken to locate that party.

c. Reasonably current credit data indicating that there is a reasonable prospect of effecting enforced collection from the debtor, having due regard for the exemptions available to the debtor under state and federal law and the judicial remedies available to the government. Such credit data may take the form of a commercial credit report; an agency investigative report showing the debtor's assets, liabilities, income, and expenses; the individual debtor's own financial statement executed under penalty of perjury reflecting the debtor's assets, liabilities, income, and expenses; or an audited balance sheet of a corporate debtor. Such credit data may be omitted if a surety bond is available in an amount sufficient to satisfy the claim in full; the forced sale value of any security available for application to the government's claim is sufficient to satisfy the claim in full; the debtor is in bankruptcy or receivership; the debtor's liability to the government is fully covered by insurance, in which case such information as can be developed concerning the identity and address of the insurer and the type and amount of insurance coverage will be furnished; or the nature of the debtor is such that credit data is not normally available or cannot reasonably be obtained, for example, a unit of state or local government.

3. Preservation of evidence. The Director, OCHAMPUS, or a designee, will take such action as is necessary to ensure that all files, records and exhibits on claims referred hereunder are properly preserved.

I. CLAIMS INVOLVING INDICATIONS OF FRAUD, FILING OF FALSE CLAIMS OR MISREPRESENTATION

Any case in which there is an indication of fraud, filing of false claims or misrepresentation will be promptly referred to the Director, OCHAMPUS, or a designee, for processing. The Director, OCHAMPUS, or a designee, will investigate and evaluate the case and either refer the case to the appropriate investigative law enforcement agency or return the claim for other appropriate administrative action, including collection action under this chapter. Payment on all CHAMPUS beneficiary or provider claims in which fraud, filing false claims or misrepresentation is suspected will be suspended until payment or denial of the claim is authorized by the Director, OCHAMPUS, or a designee. Collection action on all federal claims in which a suspicion of fraud, misrepresentation or filing false claims arises will be suspended pending referral to the appropriate law enforcement agencies by the Director, OCHAMPUS, or a designee. Only the Department of Justice has authority to compromise or terminate collection action on such claims.

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CHAPTER 12

THIRD PARTY RECOVERIES

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CHAPTER 12
THIRD PARTY RECOVERIES

A. GENERAL

This chapter deals with the right of the United States to recover the costs of medical care furnished or paid for on behalf of CHAMPUS beneficiaries from third parties. These third parties may be individuals, or entities who are liable for tort damages to the injured CHAMPUS beneficiary or a liability insurance carrier covering the individual or entity. These third parties may also include other entities who are primarily responsible to pay for the medical care provided to the injured beneficiary by reason of an insurance policy, worker's compensation law or other source of primary payment.

B. AUTHORITY

1. Federal statutory authority. The Federal Medical Care Recovery Act (reference (jj)) provides the basis under which claims may be asserted or other actions taken under this chapter. The Federal Medical Care Recovery Act is a statute enacted to authorize the recovery of the reasonable value of medical care furnished or paid for by the United States to a person who is injured or suffers a disease under circumstances creating tort liability in a third party. This Act is implemented by Executive Order 11060 and an Attorney General Regulation, 28 CFR Part 43.

2. Other authority. Third party recoveries may arise in whole or in part under authorities other than the Medical Care Recovery Act. These include, but are not limited to:

- a. State worker's compensation laws.
- b. State hospital lien laws.
- c. State no-fault or uninsured motorist statutes.
- d. Contract rights under terms of insurance policies.

C. POLICY

CHAMPUS third party recovery claims can be complex and difficult to administer because they often involve recovery potential from multiple sources. It is essential that all persons responsible for taking action under this chapter have adequate training and support in this area. The Director, OCHAMPUS, or a designee, will insure that CHAMPUS personnel (including fiscal intermediary personnel) responsible for taking any action under this chapter are adequately trained and supported to take timely and effective action. Responsibility for taking third party recovery action at various times can rest with either fiscal intermediary personnel, OCHAMPUS employees, or Uniformed Service claims asserting authorities. For this reason close coordination between those responsible for any action under this chapter is essential. Care must also be taken to insure that appropriate action to assert any third party recovery right is taken in sufficient time

to preclude the running of any applicable statute of limitations or other bar to the government's right to recover.

D. APPEALABILITY

This chapter describes the procedures to be followed in the assertion and collection of third party recovery claims in favor of the United States arising from the operation of CHAMPUS. Actions taken under this chapter are not initial determinations for the purpose of the appeal procedures of Chapter 10 of this Regulation. However, the proper exercise of the right to appeal benefit or provider status determinations under the procedures set forth in Chapter 10 may affect the processing of federal claims arising under this chapter. Those appeal procedures afford a CHAMPUS beneficiary or participating provider an opportunity for administrative appellate review in cases in which benefits have been denied and in which there is a significant factual dispute. For example, a fiscal intermediary may deny payment for services which are determined to be excluded as CHAMPUS benefits because they are found to be not medically necessary. In that event the fiscal intermediary will offer an administrative appeal as provided in Chapter 10 of this Regulation on the medical necessity issue raised by the adverse benefit determination. If the care in question results from an accidental injury and if the appeal results in a reversal of the initial determination to deny the benefit, a third party recovery claim may arise as a result of the appeal decision to pay the benefit. However, in no case is the decision to initiate such a claim itself appealable under Chapter 10 of this Regulation.

E. FEDERAL MEDICAL CARE RECOVERY ACT CLAIMS

1. General. The Federal Medical Care Recovery Act (FMCRA) (reference (jj)) provides that in any case in which the United States is authorized or required by law to furnish or pay for hospital, medical, surgical or dental care and treatment to a person who is injured or suffers a disease under circumstances creating tort liability in some third person to pay damages for that care, the United States has a right to recover from the third person the reasonable value of the care and treatment furnished or to be furnished.

2. Obligations of persons receiving treatment. To insure the expeditious and efficient processing of Federal Medical Care Recovery Act claims, any person furnished care and treatment under CHAMPUS, his or her guardian, personal representative, counsel, estate, dependents or survivors shall be required:

a. To provide complete information regarding the circumstances surrounding an injury as a condition precedent to the processing of a CHAMPUS claim involving possible third-party liability;

b. To assign in writing to the United States his or her claim or cause of action against the third person to the extent of the reasonable value of the care and treatment furnished, or to be furnished, or any portion thereof;

c. To furnish such additional information as may be requested

concerning the circumstances giving rise to the injury or disease for which care and treatment are being given and concerning any action instituted or to be instituted by or against a third person;

d. To notify the responsible recovery judge advocate, the CHAMPUS fiscal intermediary or General Counsel, OCHAMPUS, or other officer who is representing the interests of the government at the time, of a settlement with, or an offer of settlement from a third person; and,

e. To cooperate in the prosecution of all claims and actions by the United States against such third person.

3. Responsibility for recovery. The Director, OCHAMPUS, or a designee, is responsible for insuring that CHAMPUS claims arising under the Federal Medical Care Recovery Act (reference (jj)) are properly referred to and coordinated with the Uniformed Services. Generally, federal claims arising under this statute will be processed as follows:

a. Identification and referral of Federal Medical Care Recovery Act claims

(1) CHAMPUS fiscal intermediaries. In most cases where medical care is provided by civilian providers and payment for such care has been made by a CHAMPUS fiscal intermediary, initial identification of potential third-party liability will be by the CHAMPUS fiscal intermediary. In such cases, the CHAMPUS fiscal intermediary is responsible for conducting a preliminary investigation and referring the case to designated appropriate legal officers of the Uniformed Services.

(2) Initial identification by other agencies. Occasionally, cases involving potential third-party liability may be initially identified by offices, agencies or individuals other than a CHAMPUS fiscal intermediary. When this occurs, these cases should be initially referred to the General Counsel, OCHAMPUS, Aurora, CO 80045-6900 for evaluation. If appropriate, the General Counsel, OCHAMPUS, may refer the case to the fiscal intermediary or the designated Uniformed Service legal office for action.

b. Processing CHAMPUS claims. When the CHAMPUS fiscal intermediary initially identifies a claim as involving potential third-party liability, it shall request additional information concerning circumstances of the injury or disease from the beneficiary or other responsible party unless adequate information is submitted with the claim. The information normally is obtained by requesting the beneficiary to complete a personal injury questionnaire. The CHAMPUS claim will be suspended and no payment issued pending receipt of the third-party liability information. If the requested third-party liability information is not received, the claim will be denied. A CHAMPUS beneficiary may expedite the processing of his or her CHAMPUS claim by submitting a completed third-party liability questionnaire with the first claim for treatment of an accidental injury. Third-party liability information normally is required only once concerning any single accidental injury. Once the third-party liability information pertaining to

a single incident or episode of care is received, subsequent claims associated with the same incident or episode of care may be processed to payment in the usual manner. If, however, the requested third-party liability information is not received subsequent claims involving the same incident or episode of care will be suspended or denied as stated above.

c. Ascertaining total potential liability. It is essential that the legal office responsible for asserting the claim against the third party receive from the CHAMPUS fiscal intermediary a report of all amounts expended by the United States for care resulting from the incident upon which potential liability in the third party is based (including amounts paid by CHAMPUS for both inpatient and outpatient care). Prior to assertion and final settlement of a claim, it will be necessary for the responsible legal office to secure from the CHAMPUS fiscal intermediary updated information to insure that all amounts expended under CHAMPUS are included in the government's claim. It is equally important that information on future medical payments be obtained through the investigative process and included as a part of the government's claim. No CHAMPUS-related claim will be settled, compromised or waived without full consideration being given to the possible future medical payment aspects of the individual case.

4. Representing the government's interest. The government's right to recover the amounts expended for the patient's medical care is independent of the right the patient has to assert a claim against the third person for damages. The existence of the government's right, however, is dependent upon establishing the liability of the third person under ordinary principles of law.

a. Department of Justice. Frequently, collection actions under the Federal Medical Care Recovery Act (reference (jj)) must be referred to the Department of Justice for litigation. This is usually necessary because either the administrative collection action has been unsuccessful or the injured party has initiated suit and the government must be joined to protect its interests. When such referrals involve significant cases in which the dollar amount of the potential recovery on CHAMPUS claims exceeds \$40,000 or involve a unique or significant legal issue, notice of the referral will be provided to the General Counsel, OCHAMPUS. Upon request by the Uniformed Service involved, the General Counsel, OCHAMPUS, will assist in the coordination of any case with the Department of Justice.

b. Private attorneys. The attorney for the injured beneficiary may be requested to represent the interests of the government and join both claims in a single action against the third person. Such representation of the government's interest normally must be made at no expense to the government. However, when such representation of the government's interest is undertaken by the injured party's attorney for the government, offices and agencies involved will extend full cooperation to the injured party's attorney to insure that the government's interests are fully protected. The coordination of such cases is normally the responsibility of the designated Uniformed Service claims office. However, the General Counsel, OCHAMPUS, may be requested to provide assistance in coordinating CHAMPUS matters relating

to these cases. If the attorney representing the injured beneficiary does not wish to join the government's claim with that of his or her client, and court action is required to recover the amount expended for the patient's medical care, intervention or an independent suit may be initiated by the United States for the reasonable value of the care or treatment provided.

5. Settlement and waiver of Federal Medical Care Recovery Act claims

a. Authority of the Uniformed Services legal offices. Uniformed Services legal offices may, under the authority and provisions of regulations prescribed by their respective departments, (1) accept the full amount of a claim and execute a release therefore, (2) compromise or settle and execute a release of any claim, not in excess of \$40,000, which has been referred to it under the provisions of this chapter, or (3) waive, and in this connection, release any claim not in excess of \$40,000 in whole or in part, either for the convenience of the government, or if it is determined that collection would result in undue hardship upon the person who suffered the disease or injury resulting in the care and treatment provided under the CHAMPUS.

b. Department of Justice approval required. A claim in excess of \$40,000 may be compromised, settled, waived and released only with the prior approval of the Department of Justice. The Department of Justice is also to be consulted in all cases involving (1) unusual circumstances, (2) a new point of law which may serve as a precedent, or (3) a policy question where there is or may be a difference of views between federal departments and agencies.

c. Limitation on the authority of the Uniformed Services legal offices. The authority of compromise, settlement, waiver and release described by this subsection can not be exercised in any case in which (1) the claim of the United States for such care and treatment has been referred to the Department of Justice, or (2) a suit by the third party has been instituted against the United States or the individual who received or is receiving the care and treatment described herein and the suit arises out of the occurrence which gave rise to the third-party claim of the United States.

6. Reporting requirements. The Department of Defense is required to submit an annual report to the Attorney General stating the number and dollar amount of claims asserted against, and the number and dollar amount of recoveries from third persons for third-party federal claims arising from the operation of the CHAMPUS. To facilitate the preparation of this report and to maintain program integrity, the following reporting requirements are established:

a. CHAMPUS fiscal intermediaries. Each CHAMPUS fiscal intermediary shall submit on or before January 31 of each year an annual report to the Director, OCHAMPUS, or a designee, covering the 12 months of the previous calendar year. This report shall contain, as a minimum, the number and total dollar amount of cases investigated for potential third-party liability and the number and dollar amount of cases referred to Uniformed Services claims offices for further investigation and collection.

These latter figures are to be itemized by the states and Uniformed Services to which the cases are referred.

b. Uniformed Services. Each Uniformed Service will submit an annual report covering the 12 calendar months of the previous year, setting forth, as a minimum, the number and total dollar amount of cases involving CHAMPUS payments received from CHAMPUS fiscal intermediaries, the number and dollar amount of cases involving CHAMPUS payments received from other sources, and the number and dollar amount of claims actually asserted against, and the dollar amount of recoveries from, third persons. The report, itemized by state and foreign claims jurisdictions, shall be provided no later than February 28 of each year, by each Uniformed Service to the Director, OCHAMPUS, or a designee.

c. Implementation of the reporting requirements. The reporting requirements prescribed by paragraph E.6.a. above are to be implemented by the Director, OCHAMPUS, or a designee, by an appropriate action. The reporting requirements prescribed by paragraph E.6.b. above are to be implemented as soon as practicable by agreement between the Director, OCHAMPUS, or a designee, and the affected reporting agency. In no event will the reporting requirements prescribed in paragraph E.6.b. above be implemented later than December 23, 1988.

F. AUTOMOBILE OR OTHER MEDICAL PAYMENT INSURANCE, NO-FAULT INSURANCE, OR UNINSURED MOTORIST INSURANCE

Payment may not be made under CHAMPUS for any medical service or supply to the extent that payment has been made or can reasonably be expected to be made for the service or supply under medical insurance or other plan, automobile medical payment insurance policy or plan, uninsured motorist insurance, no-fault insurance or other forms of medical payments protection. Unless all or a portion of a payment under a no-fault or uninsured motorist insurance policy is designated as reimbursement for medical expenses or for some other policy benefit, the full amount of all such undesignated payments shall be deemed to be for medical expenses incurred by the policy beneficiary. Where a CHAMPUS beneficiary is covered by no-fault or uninsured motorist insurance, CHAMPUS benefits will not become available until the CHAMPUS beneficiary furnishes written documentation that he or she has incurred medical expenses equal to the full amount of the payment received under the policy, or to that portion of the total payment received which was designated for medical expenses. Based upon the results of the investigation described in paragraph E.3.b. of this chapter, the fiscal intermediary will segregate all claims involving treatment of personal injuries for which it is likely that such other insurance is available. These claims will be processed initially as double coverage claims under the provisions of Chapter 8 of this Regulation. Any CHAMPUS payments made after the double coverage provisions have been fully complied with will be considered for possible third-party liability recovery under the provisions of this chapter.

G. WORKER'S COMPENSATION CLAIMS

Based upon the results of the investigation described in paragraph

E.3.b. of this chapter, the fiscal intermediary will segregate all claims involving treatment of work-related injuries. These claims will be processed initially as double coverage claims under Chapter 8 of this Regulation dealing with worker's compensation claims. Any CHAMPUS payments made after the double coverage provisions have been fully complied with will be considered for possible third-party liability recovery under the provisions of this chapter. Unless all or a portion of a payment made pursuant to a worker's compensation claim is designated as reimbursement for medical expenses or for some other policy benefit, the full amount of all such undesignated payments shall be deemed to be for medical expenses incurred by the policy beneficiary.

H. MIXED CLAIMS

Occasionally, a claim arising under the Medical Care Recovery Act will be referred to a claims collection authority which also has some other potential for recovery. A typical example of such a claim is one arising as the result of an automobile accident in which there is a likely tortfeasor and the injured party is also covered by some combination of other health insurance which is primary to CHAMPUS, such as, worker's compensation, or a medical payments provision of an automobile policy. These claims will also initially be processed as double coverage claims. In addition, agency claims collection authorities should take full cognizance of all avenues of potential recovery as long as there is any potential for recovery from the tortfeasor. Once final action has been taken, any remaining possible recovery under the Federal Claims Collection Act (reference (ii)) may be referred to the General Counsel, OCHAMPUS, for further action in accordance with Chapter 11 of this Regulation. Such referrals should contain a complete report of all actions taken on the case and full and complete documentation of the claims involved.

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CHAPTER 13

DEPENDENTS DENTAL PLAN

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CHAPTER 13
DEPENDENTS DENTAL PLAN

A. GENERAL PROVISIONS.

1. Purpose. This section prescribes guidelines and policies for the delivery and administration of the Active Duty Dependents Dental Plan of the Uniformed Services for the Army, the Navy, the Air Force, the Marine Corps, the Coast Guard, the Commissioned Corps of the U.S. Public Health Service (USPHS), and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA).

2. Applicability

a. Geographic. This section is applicable geographically within the 50 States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the U.S. Virgin Islands.

b. Agency. The provisions of this section apply throughout the Department of Defense (DoD), the Coast Guard, the Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA.

3. Authority and responsibility

a. Legislative authority

(1) Joint regulations. 10 U.S.C. Chapter 55, 1076a authorizes the Secretary of Defense, in consultation with the Secretary of Health and Human Services and the Secretary of Transportation, to prescribe regulations for the administration of the Active Duty Dependents Dental Plan.

(2) Administration. 10 U.S.C. Chapter 55 also authorizes the Secretary of Defense to administer the Active Duty Dependents Dental Plan for the Army, Navy, Air Force, and Marine Corps under DoD jurisdiction, the Secretary of Transportation to administer the Active Duty Dependents Dental Plan for the Coast Guard, when the Coast Guard is not operating as a service in the Navy, and the Secretary of Health and Human Services to administer the Active Duty Dependents Dental Plan for the Commissioned Corps of the NOAA and the USPHS.

b. Organizational delegations and assignments

(1) Assistant Secretary of Defense (Health Affairs) (ASD(HA)). The Secretary of Defense, by DoD Directive 5136.1 (reference(b)), delegated authority to the ASD(HA) to provide policy guidance, management control, and coordination as required for all DoD health and medical resources and functional areas including health benefit programs. Implementing authority is contained in DoD 5025.1-M (reference(c)). For additional implementing authority see Chapter 1.C. of this Regulation.

(2) Evidence of eligibility. The Department of Defense, through the Defense Enrollment Eligibility Reporting System (DEERS), is responsible

for establishing and maintaining a listing of persons eligible to receive benefits under the Active Duty Dependents Dental Plan.

4. Active duty dependents dental benefit plan. This is a program of dental benefits provided by the U.S. Government under public law to specified categories of individuals who are qualified for these benefits by virtue of their relationship to one of the seven Uniformed Services, and their voluntary decision to accept enrollment in the program and cost share with the Government in the premium cost of the benefits. The Dependents Dental Plan is an insurance, service, or prepayment plan involving a contract guaranteeing the indemnification or payment of the enrolled member's dependents against a specified loss in return for a premium paid. Where state regulations, charter requirements, or other provisions of state and local regulation governing dental insurance and prepayment programs conflict with Federal law and regulation governing this Program, Federal law and regulation shall govern. Otherwise, this Program shall comply with state and local regulatory requirements.

5. Plan funds

a. Funding sources. The funds used by the Active Duty Dependents Dental Plan are appropriated funds furnished by the Congress through the annual appropriation acts for the Department of Defense and the Department of Health and Human Services and funds collected by the Uniformed Services monthly through payroll deductions as premium shares from enrolled members.

b. Disposition of funds. Plan funds are paid by the Government as premiums to an insurer, service, or prepaid dental care organization under a contract negotiated by the Director, OCHAMPUS, or a designee, under the provisions of the Federal Acquisition Regulation (FAR).

c. Plan. The Director, OCHAMPUS or designee provides an insurance policy, service plan, or prepaid contract of benefits in accordance with those prescribed by law and regulation; as interpreted and adjudicated in accord with the policy, service plan, or contract and a dental benefits brochure; and as prescribed by requirements of the dental plan organization's contract with the government.

d. Contracting out. The method of delivery of the Active Duty Dependents Dental Benefit Plan is through a competitively procured contract. The Director, OCHAMPUS, or a designee is responsible for negotiating, under provisions of the FAR, a contract for dental benefits insurance or prepayment which includes responsibility for (1) development, publication, and enforcement of benefit policy, exclusions, and limitations in compliance with the law, regulation, and the contract provisions; (B) (2) adjudicating and processing claims; and (3) conduct of related supporting activities, such as eligibility verification, provider relations, and beneficiary communications.

6. Role of Health Benefits Advisor (HBA). The HBA is appointed (generally by the commander of a Uniformed Services medical treatment facility) to serve as an advisor to patients and staff in matters involving the Active Duty Dependents Dental Plan. The HBA may assist beneficiaries or sponsors in

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applying for benefits, in the preparation of claims, and in their relations with OCHAMPUS and the dental plan insurer. However, the HBA is not responsible for the plan's policies and procedures and has no authority to make benefit determinations or obligate the plan's funds. Advice given to beneficiaries as to determination of benefits or level of payment is not binding on OCHAMPUS or the insurer.

7. Disclosure of information to the public. Records and information acquired in the administration of the Active Duty Dependents Dental Plan are not records of the Department of Defense. The records are established by the Dependents Dental Plan insurer in accordance with standard business practices of the industry, and are used in the determination of eligibility, program management and operations, utilization review, quality assurance, program integrity, and underwriting in accordance with standard business practices. By contract, the records and information are subject to government audit and the government receives reports derived from them. Records and information specified by contract are provided by an outgoing insurer to a successor insurer in the event of a change in the contractor.

8. Equality of benefits. All claims submitted for benefits under the Active Duty Dependents Dental Plan shall be adjudicated in a consistent, fair, and equitable manner, without regard to the rank of the sponsor.

9. Coordination of benefits. The dental plan insurer shall conduct coordination of benefits for the Active Duty Dependents Dental Plan in accordance with generally accepted business practices.

10. Information on participating providers. The Director, OCHAMPUS or designee, shall develop and make available to Uniformed Services Health Benefits Advisors and military installation personnel centers copies of lists of participating providers and providers accepting assignment for all localities with significant numbers of dependents of active duty members. In addition, the Director, OCHAMPUS or designee, shall respond to inquiries regarding availability of participating providers in areas not covered by the lists of participating providers.

B. DEFINITIONS

For most definitions applicable to the provisions of this section, refer to Chapter 2 of this Regulation. The following definitions apply only to this section.

Assignment. Acceptance by a nonparticipating provider of payment directly from the insurer while reserving the right to charge the beneficiary or sponsor for any remaining amount of the fees for services which exceeds the prevailing fee allowance of the insurer.

Authorized Provider. A dentist or dental hygienist specifically authorized to provide benefits under the Active Duty Dependents Dental Plan in paragraph (f) of this section.

Beneficiary. A dependent of an active duty member who has been enrolled in the Active Duty Dependents Dental Plan, and has been determined to be eligible for benefits, as set forth in paragraph (c) of this section.

Beneficiary Liability. The legal obligation of a beneficiary, his or her estate, or responsible family member to pay for the costs of dental care or treatment received. Specifically, for the purposes of services and supplies covered by the Active Duty Dependents Dental Plan, beneficiary liability includes cost-sharing amounts for restorative services, and, any amount above the prevailing fee determination by the insurer for either preventive or restorative services where the provider selected by the beneficiary is not a participating provider or a provider within an approved alternative delivery system. Beneficiary liability also includes any expenses for services and supplies not covered by the Active Duty Dependents Dental Benefit Plan, less any discount provided as a part of the insurer's agreement with an approved alternative delivery system.

By report. Dental procedures which are authorized as benefits only in unusual circumstances requiring justification of exceptional conditions related to otherwise authorized procedures. For example, a house call might be justified based on an enrolled dependent's severe handicap which prevents visits in the dentist's office for traditional prophylaxis. Alternatively, additional drugs might be required separately from an otherwise authorized procedure because of an emergent reaction caused by drug interaction during the performance of a restoration procedure. These services are further defined in paragraph (e) of this section.

Cost-Share. The amount of money for which the beneficiary (or sponsor) is responsible in connection with otherwise covered dental services (other than disallowed amounts) as set forth in Sections D and G of this Chapter. Cost-sharing may also be referred to as "co-payment."

Defense Enrollment Eligibility Reporting System (DEERS). The automated system that is composed of two phases:

1. Enrolling all active duty and retired service members, their dependents, and the dependents of deceased service members, and
2. Verifying their eligibility for health care benefits in the direct care facilities and through the Active Duty Dependents Dental Plan.

Dental hygienist. Practitioner in rendering complete oral prophylaxis services, applying medication, performing dental radiography, and providing dental education services with a certificate, associate degree, or bachelor's degree in the field, and licensed by an appropriate authority.

Dentist. Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery (D.D.S.) who is licensed to practice dentistry by an appropriate authority.

Diagnostic services. Category of dental services including (1) clinical oral examinations, (2) radiographic examinations, and (3) diagnostic laboratory tests and examinations provided in connection with other dental procedures authorized as benefits of the Active Duty Dependents Dental Plan and further defined in Section E of this Chapter.

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Emergency palliative services. Minor procedures performed for the immediate relief of pain and discomfort as further defined in Section E of this Chapter. This definition excludes those procedures other than minor palliative services which may result in the relief of pain and discomfort, but constitute the usual initial stage or conclusive treatment in procedures not otherwise defined as benefits of the Active Duty Dependents Dental Plan.

Initial Determination. A formal written decision on an Active Duty Dependents Dental Plan claim, a request by a provider for approval as an authorized provider, or a decision disqualifying or excluding a provider as an authorized provider under the Active Duty Dependents Dental Plan. Rejection of a claim or a request for benefit or provider authorization for failure to comply with administrative requirements, including failure to submit reasonably requested information, is not an initial determination. Responses to general or specific inquiries regarding Active Duty Dependent Dental Plan benefits are not initial determinations.

Laboratory and Pathology Services. Laboratory and pathology examinations (including machine diagnostic tests that produce hard-copy results) ordered by a dentist when necessary to, and rendered in connection with other covered dental services.

Nonparticipating provider. A dentist or dental hygienist that furnished dental services to an Active Duty Dependents Dental Plan beneficiary, but who has not agreed to participate or to accept the insurer's fee allowances and applicable cost share as the total charge for the services. A nonparticipating provider looks to the beneficiary or sponsor for final responsibility for payment of his or her charge, but may accept payment (assignment of benefits) directly from the insurer or assist the beneficiary in filing the claim for reimbursement by the contractor. Where the nonparticipating provider does not accept payment directly from the insurer, the insurer pays the beneficiary or sponsor, not the provider.

Participating Provider. A dentist or dental hygienist who has agreed to accept the insurer's reasonable fee allowances or other fee arrangements as the total charge (even though less than the actual billed amount), including provision for payment to the provider by the beneficiary (or sponsor) of the twenty percent cost-share for restorative services.

Party to a Hearing. An appealing party or parties, the insurer, and OCHAMPUS.

Party to the Initial Determination. Includes the Active Duty Dependents Dental Plan, a beneficiary of the Active Duty Dependents Dental Plan and a participating provider of services whose interests have been adjudicated by the initial determination. In addition, a provider who has been denied approval as an authorized Active Duty Dependents Dental Plan provider is a party to that initial determination, as is a provider who is disqualified or excluded as an authorized provider, unless the provider is excluded under another federal or federally funded program. See Section H of this Chapter for additional information concerning parties not entitled to administrative review under the Active Duty Dependents Dental Plan appeals procedures.

Preventive Services. Traditional prophylaxis including scaling deposits from teeth, polishing teeth, and topical application of fluoride to teeth as further defined in Section E of this Chapter.

Provider. A dentist or dental hygienist as specified in Section F of this Chapter.

Representative. Any person who has been appointed by a party to the initial determination as counsel or advisor and who is otherwise eligible to serve as the counsel or advisor of the party to the initial determination, particularly in connection with a hearing.

Restorative services. Restoration of teeth including those procedures commonly described as amalgam restorations, resin restorations, pin retention, and stainless steel crowns for primary teeth as further defined in Section E of this Chapter.

C. ENROLLMENT AND ELIGIBILITY

1. General. Sections 1076a and 1072(2)(D) of 10 U.S.C., Chapter 55 set forth those persons who are eligible for voluntary enrollment in the Active Duty Dependents Dental Benefit Plan. A determination that a person is eligible for voluntary enrollment does not entitle such a person automatically to benefit payments. The active duty member must enroll his or her dependents as defined in this Chapter, and other Chapters of this Regulation set forth additional requirements that must be met before eligibility for the plan is extended.

2. Persons eligible. Dependent. A person who bears one of the following relationships to an active duty member (under a call or order that does not specify a period of 30 days or less):

a. Spouse. A lawful husband or wife, regardless of whether or not dependent upon the active duty member.

b. Child. To be eligible, the child must be unmarried and meet one of the requirements of this section.

(1) A legitimate child.

(2) An adopted child whose adoption has been completed legally.

(3) A legitimate stepchild.

(4) An illegitimate child of a male member whose paternity has been determined judicially, or an illegitimate child of record of a female member who has been directed judicially to support the child.

(5) An illegitimate child of a male active duty member whose paternity has not been determined judicially, or an illegitimate child of record of a female active duty member who:

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(a) Resides with or in a home provided by the member and

(b) Is and continues to be dependent upon the member for over 50 percent of his or her support.

(6) An illegitimate child of the spouse of an active duty member (that is, the active duty member's stepchild) who:

(a) Resides with or in a home provided by the active duty member or the parent who is the spouse of the member and

(b) Is and continues to be dependent upon the member for over 50 percent of his or her support.

(7) In addition to meeting one of the criteria (1) through (6) of this paragraph C.2., the child:

(a) Must not be married.

(b) Must be in one of the following three age groups:

1 Not passed his or her 21st birthday.

2 Passed his or her 21st birthday, but incapable of self-support because of a mental or physical incapacity that existed before his or her 21st birthday and dependent on the member for over 50 percent of his or her support. Such incapacity must be continuous. If the incapacity significantly improves or ceases at any time after age 21, even if such incapacity recurs subsequently, eligibility cannot be reinstated on the basis of the incapacity. If the child was not handicapped mentally or physically at his or her 21st birthday, but becomes so incapacitated after that time, no eligibility exists on the basis of the incapacity.

3 Passed his or her 21st birthday, but not his or her 23rd birthday, dependent upon the member for over 50 percent of his or her support, and pursuing a full-time course of education in an institution of higher learning approved by the Secretary of Defense or the Department of Education (as appropriate) or by a state agency under 38 U.S.C., Chapters 34 and 35.

NOTE: Courses of education offered by institutions listed in the "Education Directory, Part 3, Higher Education" or "Accredited Higher Institutions," issued periodically by the Department of Education meet the criteria approved by the Secretary of Defense or the Department of Education, (refer to Chapter 3, B.2.d.(3)(c) of this Regulation). For determination of approval of courses offered by a foreign institution, by an institution not listed in either of the above directories, or by an institution not approved by a state agency pursuant to Chapters 34 and 35 of 38 U.S.C., a statement may be obtained from the Department of Education, Washington, D.C. 20202.

3. Enrollment

a. Initial enrollment. Eligible dependents of members on active duty status as of August 1, 1987 are automatically enrolled in the Active Duty Dependents Dental Benefit Plan, except where any of the following conditions apply:

(1) Remaining period of active duty at the time of contemplated enrollment is expected by the active duty member or the Uniformed Service to be less than two years, except that such members' dependents may be enrolled during the initial enrollment period for benefits beginning August 1, 1987 provided that the member has at least six months remaining in the initial enlistment term. Enrollment of dependents is for a period of two years, subject to the exceptions provided in C.5.

(2) Active duty member has completed an election to disenroll his or her dependents from the Active Duty Dependents Dental Plan.

(3) Active duty member has only one dependent who is under four years of age as of August 1, 1987, and the member does not complete an election to enroll the child.

b. Subsequent enrollment. Eligible active duty members may elect to enroll their dependents for a period of not less than two years, provided there is an intent to remain on active duty for a period of not less than two years by the member and the Uniformed Service.

c. Inclusive family enrollment. All eligible dependents of the active duty member must be enrolled if any are enrolled, except that a member may elect to enroll only those dependents who are remotely located from the member (e.g., a child living with a divorced spouse or a child in college).

4. Beginning dates of eligibility

a. Initial enrollment. The beginning date of eligibility for benefits is August 1, 1987.

b. Subsequent enrollment. The beginning date of eligibility for benefits is the first day of the month following the month in which the election of enrollment is completed, signed, and received by the active duty member's Service representative, except that the date of eligibility shall not be earlier than September 1, 1987.

5. Changes in and termination of enrollment

a. Changes in status of active duty member. When an active duty member's period of active duty ends for any reason, his or her dependents lose their eligibility as of 11:59 p.m. of the last day of the month in which the active duty ends.

b. Termination of eligibility for basic pay. When a member ceases to be eligible for basic pay, eligibility of the member's dependents for

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benefits under the Dependents Dental Plan terminates as of 11:59 p.m. of the day the member became ineligible for basic pay and the Uniformed Service must notify the Plan of disenrollment based on termination of eligibility for basic pay. The member whose eligibility for basic pay is subsequently restored may enroll his or her dependents for a minimum of two years in accordance with C.3.b.

c. Changes in status of dependent

(1) Divorce. A spouse separated from an active duty member by a final divorce decree loses all eligibility based on his or her former marital relationship as of 11:59 p.m. of the last day of the month in which the divorce becomes final. The eligibility of the member's own children (including adopted and eligible illegitimate children) is unaffected by the divorce. An unadopted stepchild, however, loses eligibility with the termination of the marriage, also as of 11:59 p.m. the last day of the month in which the divorce becomes final.

(2) Annulment. A spouse whose marriage to an active duty member is dissolved by annulment loses eligibility as of 11:59 p.m. of the last day of the month in which the court grants the annulment order. The fact that the annulment legally declares the entire marriage void from its inception does not affect the termination date of eligibility. When there are children, the eligibility of the member's own children (including adopted and eligible illegitimate children) is unaffected by the annulment. An unadopted stepchild, however, loses eligibility with the annulment of the marriage, also as of 11:59 p.m. of the last day of the month in which the court grants the annulment order.

(3) Adoption. A child of an active duty member who is adopted by a person, other than a person whose dependents are eligible for the Active Duty Dependents Dental Plan benefits while the active duty member is living, thereby severing the legal relationship between the child and the sponsor, loses eligibility as of 11:59 p.m. of the last day of the month in which the adoption becomes final.

(4) Marriage of child. A child of an active duty member who marries a person whose dependents are not eligible for the Active Duty Dependents Dental Plan, loses eligibility as of 11:59 p.m. on the last day of the month in which the marriage takes place. However, should the marriage be terminated by death, divorce, or annulment before the child is 21 years old, the child again becomes eligible for enrollment as a dependent as of 12:00 a.m. of the first day of the month following the month in which the occurrence takes place that terminates the marriage and continues up to age 21 if the child does not remarry before that time. If the marriage terminates after the child's 21st birthday, there is no reinstatement of eligibility.

(5) Disabling illness or injury of child age 21 or 22 who has eligibility based on his or her student status. A child 21 or 22 years old who is pursuing a full-time course of higher education and who, either during the school year or between semesters, suffers a disabling illness or injury

with resultant inability to resume attendance at the institution remains eligible for dental benefits for 6 months after the disability is removed or until the student passes his or her 23rd birthday, whichever occurs first. However, if recovery occurs before the 23rd birthday and there is resumption of a full-time course of higher education, dental benefits can be continued until the 23rd birthday. The normal vacation periods during an established school year do not change the eligibility status of a dependent child 21 or 22 years old in full-time student status. Unless an incapacitating condition existed before, and at the time of, a dependent child's 21st birthday, a dependent child 21 or 22 years old in student status does not have eligibility related to mental or physical incapacity as described in Chapter 3, B.2.d.(3)(b) of this Regulation.

d. Disenrollment because of no eligible dependents. When an active duty member ceases to have any eligible dependents residing within the Plan's jurisdiction, the member must disenroll.

e. Option to disenroll as a result of a change in active duty station. When an active duty member makes a permanent change in duty station resulting in a move of more than 50 miles of his or her dependents to a new locality, the member may elect within 90 days of the change to disenroll from the Plan if dental care for these benefits is available from a local military dental clinic available to the member's dependents.

f. Option to disenroll as a result of electing other dental insurance coverage. When an active duty member's dependents become enrolled in another employment-based dental insurance plan, the member may elect to disenroll from the Active Duty Dependents Dental Plan. Proof of other employment-based dental insurance coverage must be provided to the appropriate Service representative prior to approval of disenrollment.

g. Option to disenroll after an initial two-year enrollment. When an active duty member's enrollment of his or her dependents has been in effect for a continuous period of two years, the member may disenroll his or her dependents at any time. Subsequently, the member may enroll his or her dependents for another minimum period of two years.

6. Eligibility determination and enrollment

a. Eligibility determination and enrollment responsibility of Uniformed Services. Determination of a person's eligibility and processing of enrollment in the Active Duty Dependents Dental Benefit Plan is the responsibility of the active duty member's Uniformed Service. For the purpose of program integrity, the appropriate Uniformed Service shall, upon request of the Director, OCHAMPUS, review the eligibility of a specific person when there is reason to question the eligibility status. In such cases, a report on the result of the review and any action taken will be submitted to the Director, OCHAMPUS, or a designee.

b. Procedures for determination of eligibility. Uniformed Services identification cards do not distinguish eligibility for the Active Duty Dependents Dental Plan. Procedures for the determination of eligibility are

identified in Chapter 3, F.2. of this Regulation, except that Uniformed Services identification cards do not provide evidence of eligibility for the dental plan.

7. Evidence of eligibility required. Eligibility and enrollment in the Active Duty Dependents Dental Plan will be verified through the DEERS (DoD 1341.1-M, "Defense Enrollment Eligibility Reporting System (DEERS) Program Manual," May 1982).

a. Acceptable evidence of eligibility and enrollment. Eligibility information established and maintained in the DEERS files is the only acceptable evidence of eligibility.

b. Responsibility for obtaining evidence of eligibility. It is the responsibility of the active duty member, or Active Duty Dependent Dental Plan beneficiary, parent, or legal representative, when appropriate, to enroll with a Uniformed Service authorized representative and provide adequate evidence for entry into the DEERS file to establish eligibility for the Active Duty Dependents Dental Plan, and to ensure that all changes in status that may affect enrollment and eligibility are reported immediately to the appropriate Uniformed Service for action. Ineligibility for benefits is presumed in the absence of prescribed enrollment and eligibility evidence in the DEERS file.

D. PREMIUM SHARING

1. General. Active duty members enrolling their dependents in the Active Duty Dependents Dental Plan shall be required to pay a share of the premium cost for their dependents.

2. Premium classifications. Premium classifications are established by the Secretary of Defense, or designee, and provide for a minimum of two classifications, single and family.

3. Premium amounts. The premium amounts to be paid for the Active Duty Dependents Dental plan are established by the Secretary of Defense or designee.

4. Proportion of member's premium share. The proportion of premium share to be paid by the member is established by the Secretary of Defense or designee, at not more than 40 percent of the total premium.

5. Pay deduction. The member's premium share shall be deducted from the basic pay of the member.

E. PLAN BENEFITS

1. General

a. Scope of benefits. The Active Duty Dependents Dental Plan provides coverage for certain basic dental diagnostic, minor palliative emergency, preventive, and restorative services to eligible, enrolled dependents of active duty members as set forth in Section C. of this Chapter.

b. Authority to act for the plan. The authority to make benefit determinations and authorize plan payments under the Active Duty Dependents Dental Plan rests primarily with the insurance, service plan, or prepayment dental plan contractor, subject to compliance with federal law and regulation and government contract provisions. The Director, OCHAMPUS, or designee, provides required benefit policy decisions resulting from changes in federal law and regulation and appeal decisions. No other persons or agents (such as dentists or Uniformed Services health benefits advisors) have such authority.

c. Right to information. As a condition precedent to the provision of benefits hereunder, the Director, OCHAMPUS, or designee, shall be entitled to receive information from an authorized provider or other person, institution, or organization (including a local, state, or U.S. Government agency) providing services or supplies to the beneficiary for which claims for benefits are submitted. While establishing enrollment and eligibility, benefits, and benefit utilization and performance reporting information standards; the government has not established and does not maintain a system of records and information for the Dependents Dental Plan. By contract, the government audits the adequacy and accuracy of the dental contractor's system of records and requires access to information and records to meet program accountabilities. Such information and records may relate to attendance, testing, monitoring, examination, or diagnosis of dental disease or conditions; or treatment rendered; or services and supplies furnished to a beneficiary; and shall be necessary for the accurate and efficient administration and payment of benefits under this plan. Before a determination will be made on a claim of benefits, a beneficiary or active duty member must provide particular additional information relevant to the requested determination, when necessary. Failure to provide the requested information may result in denial of the claim. The recipient of such information shall in every case hold such records confidential except when:

(1) Disclosure of such information is necessary to the determination by a provider or the Plan contractor of beneficiary enrollment or eligibility for coverage of specific services;

(2) Disclosure of such information is authorized specifically by the beneficiary;

(3) Disclosure is necessary to permit authorized governmental officials to investigate and prosecute criminal actions; or

(4) Disclosure constitutes a standard and acceptable business practice commonly used among dental insurers which is consistent with the principle of preserving confidentiality of personal information and detailed clinical data. For example, the release of utilization information for the purpose of determining eligibility for certain services, such as the number of dental prophylaxis procedures performed for a beneficiary, is authorized.

(5) Disclosure by the Director, OCHAMPUS, or designee, is for the purpose of determining the applicability of, and implementing the provisions of, other dental benefits coverage or entitlement.

NOTE: Release by the recipient of the information under the confidentiality exceptions identified in E.1.c. is authorized without consent or notice to any beneficiary or sponsor, to any person, organization, government agency, provider, or other entity.

d. Dental insurance policy, prepayment, or dental service plan contract. The Director, OCHAMPUS, or designee, shall develop a standard insurance policy, prepayment agreement, or dental service plan contract designating OCHAMPUS as the policyholder or purchaser. The policy shall be in the form customarily employed by the dental plan insurer, subject to its compliance with federal law and the provisions of this Regulation.

e. Dental benefits brochure

(1) Content. The Director, OCHAMPUS, or designee shall establish a dental benefits brochure explaining the benefits of the plan in common lay terminology. The brochure shall include the limitations and exclusions and other benefit determination rules for administering the benefits in accordance with the law and this part. The brochure shall include the rules for adjudication and payment of claims, appealable issues, and appeal procedures in sufficient detail to serve as a common basis for interpretation and understanding of the rules by providers, beneficiaries, claims examiners, correspondence specialists, employees and representatives of other government bodies, health benefits advisors, and other interested parties. Any conflict which may occur between the dental benefits brochure and law or regulation shall be resolved in favor of law and regulation.

(2) Distribution. The dental benefits brochure shall be printed and distributed with the assistance of the Uniformed Services health benefits advisors, major personnel centers at Uniformed Services installations, and authorized providers of care to all active duty members enrolling their dependents.

f. Utilization review and quality assurance. Claims submitted for benefits under the Active Duty Dependents Dental Plan are subject to review by the Director, OCHAMPUS or designee for quality of care and appropriate utilization. The Director, OCHAMPUS or designee is responsible for appropriate utilization review and quality assurance standards, norms, and criteria consistent with the level of benefits.

g. Alternative course of treatment policy. The Director, OCHAMPUS or designee may establish, in accordance with generally accepted dental benefit practices, an alternative course of treatment policy which provides reimbursement in instances where the dentist and beneficiary select a more expensive service, procedure, or course of treatment than is customarily provided. The benefit policy must meet the following conditions:

(1) The service, procedure, or course of treatment must be consistent with sound professional standards of dental practice for the dental condition concerned.

(2) the service, procedure, or course of treatment must be a generally accepted alternative for a service or procedure covered by this plan for the dental condition.

(3) payment for the alternative service or procedure may not exceed the lower of the prevailing limits for the alternative procedure, the prevailing limits or scheduled allowance for the otherwise authorized benefit procedure for which the alternative is substituted, or the actual charge for the alternative procedure.

2. Benefits

a. Diagnostic, preventive, and emergency palliative services.

Benefits may be extended for those dental services described as oral examination, diagnostic, emergency minor palliative, and preventive services defined as traditional prophylaxis (i.e., scaling deposits from teeth, polishing teeth, and topical application of fluoride to teeth) when performed directly by dentists or dental hygienists as authorized under Section F of this Chapter. Diagnostic and by report services are covered only when they are necessary to covered preventive and restorative procedures. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules approved by OCHAMPUS) using the American Dental Association, The Council on Dental Care Programs' Code On Dental Procedures and Nomenclature as follows:

(1) Diagnostic

(a) Clinical oral examinations including initial (00110), periodic (00120), and emergency (00130).

(b) Radiographs appropriate to the diagnosis and prevention of dental disease, where such services are not directly related to noncovered major procedures. Subject to the dental plan's exclusions and limitations approved by OCHAMPUS, these procedures are included within the range of 00210 to 00340. Procedures 00290 (posterior-anterior or lateral skull and facial bone survey film), 00315 (sialography), 00320 (temporomandibular joint arthrogram), 00321 (other temporomandibular joint films), and 00340 (cephalo-metric film) are excluded.

(c) Tests and laboratory examinations appropriate to the diagnosis and prevention of dental disease, where such services are not directly related to non-covered major procedures. These procedures are included within the range of 00410 to 00999, subject to the dental plan's exclusions and limitations as adopted by OCHAMPUS. Procedures 00415 (bacteriologic studies to determine pathologic agents), 00470 (diagnostic casts), 00471 (diagnostic photographs), 00501 (histopathologic examinations), 00502 (other oral pathology procedures), and 00999 (unspecified diagnostic procedures) are excluded.

(2) Preventive

(a) Dental prophylaxis, including adult (01110) and child (01120).

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(b) Topical fluoride treatment, including prophylaxis for a child (01201) and an adult (01205), and (where the Director, OCHAMPUS or designee determines to be appropriate) without prophylaxis for a child (01203) and an adult (01204).

(c) Space maintenance with passive appliances for those procedures included within the range of 01510 and 01550.

(3) Emergency palliative. Minor palliative procedure for immediate and temporary relief of pain and suffering (09110).

b. Restorative. Benefits may be extended for basic restorative services of amalgam, composite restorations, and stainless steel crowns for primary teeth when performed directly by dentists or dental hygienists, or under orders and supervision by dentists, as authorized under section F. of this Chapter. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association, Council on Dental Care Programs' Code On Dental Procedures and Nomenclature as follows:

(1) Amalgam restorations, including polishing of one to four or more surfaces for primary and permanent teeth and included within the range of 02110 and 02161.

(2) Silicate restorations (02210).

(3) Resin restorations (subject to accepted dental practice) of one to four surfaces and included within the range of 02330 and 02387.

(4) Stainless steel crown for primary tooth (02930).

(5) Pin retention (02951).

c. Dental appliance repairs. Benefits may be extended for repairs to completely removable dentures when performed directly by dentists, or under orders and supervision by dentists as authorized under section F. of this Chapter; subject to the dental plan's exclusions and limitations as adopted by OCHAMPUS. These procedures are included within the range of 05510 and 05660.

d. Services "By Report." The following procedures are authorized when performed directly by dentists or dental hygienists only in unusual circumstances requiring justification of exceptional conditions directly related to otherwise authorized procedures. They are generally reserved for use where mental or physical impairments prevent the rendering of otherwise authorized procedures of this dental plan without one or more of these additional services. Use of the procedures may not result in the fragmentation of services normally included in a single procedure. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association, Council on Dental Care Programs' Code On Dental Procedures and Nomenclature as follows:

- (1) Consultation (09310).
- (2) House call (09440)
- (3) Hospital call (09420).
- (4) Office visit (after hours--09440).
- (5) Drug injection (09610).
- (6) Other prescription drugs (09630).

e. Exclusion of adjunctive dental care. Under limited circumstances, benefits are available for dental services and supplies under CHAMPUS when the dental care is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition, and is essential to the control of the primary medical condition; or is required in preparation for or as the result of dental trauma which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic). These benefits are excluded under the Active Duty Dependents Dental Plan. For further information on adjunctive dental care benefits under CHAMPUS, see Chapter 4 E.10. a. and b. of this part.

f. Exclusion of benefit services performed in military dental care facilities. Except for emergency treatment and services incidental to non-covered services, dependents enrolled in the Active Duty Dependents Dental Plan may not obtain those services which are benefits of the Plan in military dental care facilities. Enrolled dependents may continue to obtain non-covered services from military dental care facilities subject to the provisions for space available care.

g. Benefit limitations and exclusions. The Director, OCHAMPUS or designee may establish such exclusions and limitations as are consistent with those established by dental insurance and prepayment plans to control utilization and quality of care for the services and items covered by this dental plan.

3. Beneficiary or sponsor liability

a. Diagnostic, preventive, and emergency palliative services. Enrolled dependents of active duty members or their sponsors are responsible for the payment of only amounts for services rendered by nonparticipating providers of care which exceed the equivalent of the statewide or regional prevailing fee levels as established by the insurer. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, the dental plan will reimburse the dependent, or sponsor, or the nonparticipating provider selected by the dependent within 35 miles of the dependent's place of residence at the level of the provider's usual fees.

b. Restorative services. Enrolled dependents of active duty members or their sponsors are responsible for payment of 20 percent of the amounts determined by the insurer for services rendered by participating providers of care or 20 percent of these amounts plus any remainder of the charges made by nonparticipating providers of care. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, dependents or their sponsors are responsible for payment of 20 percent of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence.

c. Dental appliance repairs. Enrolled dependents of active duty members are responsible for payment of the cost sharing amounts as provided in subparagraph E.3.b. immediately above.

d. Services "by report." Enrolled dependents of active duty members or their sponsors are responsible for payment of these services in accordance with their relationship to the otherwise authorized benefit procedures. For example, home visit charges which occur primarily for the purpose of rendering restorative services require payment of the 20 percent, while a home visit for purposes of dental prophylaxis do not require payment of the 20 percent. Payment of any remaining amount in excess of the prevailing charge limits established by the insurer would be required for services rendered by nonparticipating providers in either of the examples given, subject to the exceptions for dependent lack of access to participating providers as provided in a. and b. of this section. The contracting dental insurer may recognize a "by report" condition by providing an additional allowance to the primary covered procedure instead of recognizing or permitting a distinct billing for the "by report" service.

e. Amounts over the dental insurer's established allowances for charges. It is the responsibility of the dental plan insurer to determine allowable charges for the procedures identified as benefits of this plan. All benefits of the plan are based on the insurer's determination of the allowable charges, subject to the exceptions for lack of access to participating providers as provided in subparagraphs E.3.a. and b. above.

F. AUTHORIZED PROVIDERS

1. General. This section sets forth general policies and procedures that are the basis for the Active Duty Dependents Dental Plan cost sharing of dental services and supplies provided by or under the direct supervision or prescription by dentists, and by dental hygienists, within the scope of their licensure.

a. Listing of provider does not guarantee payment of benefits. The fact that a type of provider is listed in this section is not to be construed to mean that the Active Duty Dependents Dental Plan will pay automatically a claim for services or supplies provided by such a provider. The Director, OCHAMPUS or designee also must determine if the patient is an eligible beneficiary, whether the services or supplies billed are authorized and medically

necessary, and whether any of the authorized exclusions of otherwise qualified providers presented in this section apply.

b. Conflict of interest. See Chapter 9, D.2.d. of this Regulation.

c. Fraudulent practices or procedures. See Chapter 9, C. of this Regulation.

d. Utilization review and quality assurance. Services and supplies furnished by providers of care shall be subject to utilization review and quality assurance standards, norms, and criteria established by the dental plan. Utilization review and quality assurance assessments shall be performed by the dental plan consistent with the nature and level of benefits of the plan, and shall include analysis of the data and findings by the dental plan insurer from other dental accounts.

e. Provider required. In order to be considered benefits, all services and supplies shall be rendered by, prescribed by, or furnished at the direction of, or on the order of an Active Duty Dependents Dental Plan authorized provider practicing within the scope of his or her license.

f. Participating provider. An authorized provider may elect to participate and accept the fee or charge determinations as established and made known to the provider by the dental plan insurer. The fee or charge determinations are binding upon the provider in accordance with the dental plan insurer's procedures for participation. The authorized provider may not participate on a claim-by-claim basis. The participating provider must agree to accept within one day of a request for appointment, beneficiaries in need of emergency palliative treatment. Payment to the participating provider is based on the lower of the actual charge or the insurer's determination of the allowable charge. Payment is made directly to the participating provider, and the participating provider may charge the beneficiary only for the 20 percent cost share of the allowable charge for authorized restorative services in addition to the charges for any services not authorized as benefits.

g. Nonparticipating provider. An authorized provider may elect for all beneficiaries not to participate and request the beneficiary or sponsor to pay any amount of the provider's billed charge in excess of the dental plan insurer's determination of allowable charges. Neither the government nor the dental plan insurer shall have any responsibility for any amounts over the allowable charges as determined by the dental plan insurer, except where the dental plan insurer is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days. In such instances of the nonavailability of a participating provider, the nonparticipating provider located within 35 miles of the dependent's place of residence shall be paid his or her usual fees, less the 20 percent cost share for restorative services and related services by report.

(1) Assignment. A nonparticipating provider may accept assignment of claims for beneficiaries certifying their willingness to make

such assignment by filing the claims completed with the assistance of the beneficiary or sponsor for direct payment by the dental plan insurer to the provider.

(2) Nonassignment. A nonparticipating provider for all beneficiaries may request the beneficiary or sponsor to file the claim directly with the dental plan insurer, making arrangements with the beneficiary or sponsor for direct payment by the beneficiary or sponsor.

2. Dentists. Subject to standards of participation provisions of this part, the following are authorized providers of care:

a. Doctors of Dental Surgery (D.D.S.) having a degree from an accredited school of dentistry, licensed to practice dentistry by a state board of dental examiners, and practicing within the scope of their licenses, whether in individual, group, or clinic practice settings.

b. Doctors of Dental Medicine (D.M.D.) having a degree from an accredited school of dentistry, licensed to practice dentistry by a state board of dental examiners, and practicing within the scope of their licenses, whether in individual, group, or clinic practice settings.

3. Dental hygienists. Subject to state licensure laws and standards of participation provisions of this part, dental hygienists having either an associate degree, certificate, or baccalaureate degree from an accredited school of dental hygiene, licensed to practice dental hygiene by a state board, and practicing within the scope of their licenses, whether in individual, group, or clinic practice settings.

NOTE: Dental hygienists may independently bill and receive payment only in a few states where state licensure laws authorize them as independent providers of care. In nearly all states at the present time, the dental hygienist performs services under the supervision of a dentist and the Dependents Dental Plan will pay for such services in these states only when supervised and billed by a dentist.

4. Alternative delivery systems

a. General. Alternative delivery systems may be established by the Director, OCHAMPUS or designee as authorized providers. Only dentists and dental hygienists shall be authorized to provide or direct the provision of authorized services and supplies in an approved alternative delivery system.

b. Defined. An alternative delivery system may be any approved arrangement for a preferred provider organization, capitation plan, dental health maintenance or clinic organization, or other contracted arrangement which is approved by OCHAMPUS in accordance with requirements and guidelines.

c. Elective or exclusive arrangement. Alternative delivery systems may be established by contract or other arrangement on either an elective or exclusive basis for beneficiary selection of participating and authorized providers in accordance with contractual requirements and guidelines.

d. Provider election of participation. Otherwise authorized providers must be provided with the opportunity of applying for participation in an alternative delivery system and of achieving participation status based on reasonable criteria for timeliness of application, quality of care, cost containment, geographic location, patient availability, and acceptance of reimbursement allowances.

e. Limitation on authorized providers. Where exclusive alternative delivery systems are established, only providers participating in the alternative delivery system are authorized providers of care. In such instances, the dental plan shall continue to pay beneficiary claims for services rendered by otherwise authorized providers in accordance with established rules for reimbursement of nonparticipating providers where the beneficiary has established a patient relationship with the nonparticipating provider prior to the dental plan's proposal to subcontract with the alternative delivery system.

f. Charge agreements. Where the alternative delivery system employs a discounted fee-for-service reimbursement methodology or schedule of charges or rates which includes all or most dental services and procedures recognized by the American Dental Association, Council on Dental Care Programs "Code on Dental Procedures and Nomenclature," the discounts or schedule of charges or rates for all dental services and procedures shall be extended by its participating providers to beneficiaries of the Active Duty Dependents Dental Plan as an incentive for beneficiary participation in the alternative delivery system.

5. Billing practices. The Director, OCHAMPUS, or designee, approves the dental plan's procedures governing the itemization and completion of claims for services rendered by authorized providers to enrolled beneficiaries of the Active Duty Dependents Dental Plan consistent with the insurer's existing procedures for completion and submittal of dental claims for its other dental plans and accounts.

6. Reimbursement of authorized providers. The Director, OCHAMPUS or designee, approves the dental plan methodology for reimbursement of services rendered by authorized providers consistent with law, regulation, and contract provisions, and the benefits of the Active Duty Dependents Dental Plan. The following general requirements for the methodology shall be met, subject to modifications and exceptions approved by the Director, OCHAMPUS or a designee.

a. Nonparticipating providers (or the dependents or sponsors for unassigned claims) shall be reimbursed at the equivalent of not less than the 50th percentile of prevailing charges made for similar services in the same locality (region) or state, or the provider's actual charge, whichever is lower; less any cost share amount due for restorative services, except where

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the dental plan insurer is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days. In such instances of the nonavailability of a participating provider, the nonparticipating provider located within 35 miles of the dependent's place of residence shall be paid his or her usual fees, less the 20 percent cost share for restorative services and related services by report.

b. Participating providers shall be reimbursed at the equivalent of a percentile of prevailing charges sufficiently above the 50th percentile of prevailing charges made for similar services in the same locality (region) or state as to constitute a significant financial incentive for participation, or the provider's actual charge, whichever is lower; less any cost share amount due for restorative services.

G. BENEFIT PAYMENT

1. General. Active Duty Dependent Dental Plan benefit payments are made either directly to the provider or to the beneficiary or sponsor, depending on the manner in which the claim is submitted or the terms of the subcontract of an alternative delivery system with the dental plan insurer.

2. Benefit payments made to a participating provider. When the authorized provider has elected to participate in accordance with the arrangement and procedures established by the dental plan insurer, payment is made based on the lower of the actual charge or the insurer's determination of the allowable charge. Payment is made directly to the participating provider as payment in full, less the 20 percent cost share of the allowable charge for any of the restorative services authorized as benefits. The beneficiary or sponsor is responsible only for any required cost-sharing.

3. Benefit payments made to a nonparticipating provider. When the authorized provider has elected not to participate in accordance with the arrangement and procedures established by the dental plan, payment is made by the insurer based on the lower of the actual charge or the insurer's determination of the allowable charge. The beneficiary is responsible for payment of the 20 percent cost-share of the allowable charge for any restorative services authorized as benefits, and any amount of the charge for all services above the allowable charge. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, dependents or their sponsors are responsible for payment of 20 percent of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence.

a. Assigned claims are claims submitted directly by the nonparticipating provider and are paid directly to the provider.

b. Nonassigned claims are claims submitted by the beneficiary, provider, or sponsor and are paid directly to the claimant.

4. Dental Explanation of Benefits (DEOB). An explanation of benefits is sent to the beneficiary or sponsor and provides the following information:

- a. Name and address of the beneficiary.
- b. Social Security Account Number (SSAN) of the sponsor.
- c. Name and address of the provider.
- d. Services or supplies covered by the claim for which the DEOB applies.
- e. Dates the services or supplies were provided.
- f. Amount billed; allowable charge; and amount of payment.
- g. To whom payment, if any, was made.
- h. Reasons for any denial.
- i. Recourse available to beneficiary for review of claim decision (refer to section H. of this Chapter).

5. Fraud

a. Federal laws. 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious, or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States. Examples of fraud include situations in which ineligible persons not enrolled in the Active Duty Dependents Dental Plan obtain care and file claims for benefits under the name and identification of an enrolled beneficiary; or when providers submit claims for services and supplies not rendered to enrolled beneficiaries; or when a participating provider bills the beneficiary for amounts over the dental plan insurer's determination of allowable charges; or fails to collect the specified patient copayment amount.

b. Suspected fraud. Any person, including the dental plan insurer, who becomes aware of a suspected fraud shall report the circumstances in writing, together with copies of any available documents pertaining thereto, to the Director, OCHAMPUS, or a designee, who shall initiate an official investigation of the case.

H. APPEAL AND HEARING PROCEDURES

1. General. This section sets forth the policies and procedures for appealing decisions made by the dental plan adversely affecting the rights and liabilities of beneficiaries, participating providers, and providers denied the status of authorized provider under the Active Duty Dependents Dental Plan. An appeal under the Active Duty Dependents Dental Plan is an administrative review of program determinations made under the provisions of law and regulation. An appeal cannot challenge the propriety, equity, or legality of any provision of law and regulation.

a. Initial determination

(1) Notice of initial determination and right to appeal

(a) The dental plan contractor shall mail notices of initial determinations to the Active Duty Dependents Dental Plan beneficiary at the last known address. For beneficiaries who are under 18 years of age or who are incompetent, a notice issued to the parent or guardian constitutes notice to the beneficiary.

(b) The dental plan contractor shall notify providers of an initial determination on a claim only if the providers participated in the claim or accepted assignment.

(c) Notice of an initial determination on a claim by the dental plan contractor shall be made in the contractor's explanation of benefits (beneficiary) or with the summary of payment (provider).

(d) Each notice of an initial determination on a request for benefit authorization, a request by a provider for approval as an authorized provider, or a decision to disqualify or exclude a provider as an authorized provider under the Active Duty Dependents Dental Plan shall state the reason for the determination and the underlying facts supporting the determination.

(e) In any case when the initial determination is adverse to the beneficiary or participating provider or to the provider seeking approval as an authorized provider, the notice shall include a statement of the beneficiary's or provider's right to appeal the determination. The procedure for filing the appeal also shall be explained.

(2) Effect of initial determination. The initial determination is final, unless appealed in accordance with this section or unless the initial determination is reopened by OCHAMPUS or the dental plan contractor.

b. Participation in an appeal. Participation in an appeal is limited to any party to the initial determination, including OCHAMPUS, the dental plan contractor, and authorized representatives of the parties. Any party to the initial determination, except OCHAMPUS and the dental plan contractor, may appeal an adverse determination. The appealing party is the party who actually files the appeal.

(1) Parties to the initial determination. For purposes of these appeal and hearing procedures, the following are not parties to an initial determination and are not entitled to administrative review under this section.

(a) A provider disqualified or excluded as an authorized provider under the Active Duty Dependents Dental Plan based on a determination under another Federal or federally funded program is not a party to the OCHAMPUS action and may not appeal under this section.

(b) A sponsor or parent of a beneficiary under 18 years of age or guardian of an incompetent beneficiary is not a party to the initial determination and may not serve as the appealing party, although such persons may represent the appealing party in an appeal.

(c) A third party other than the dental plan contractor, such as an insurance company, is not a party to the initial determination and is not entitled to appeal, even though it may have an indirect interest in the initial determination.

(d) A nonparticipating provider is not a party to the initial determination and may not appeal.

(2) Representative. Any party to the initial determination may appoint a representative to act on behalf of the party in connection with an appeal. Generally, the parent of a minor beneficiary and the legally appointed guardian of an incompetent beneficiary shall be presumed to have been appointed representative without specific designation by the beneficiary.

(a) The representative shall have the same authority as the party to the appeal, and notice given to the representative shall constitute notice required to be given to the party under this part.

(b) To avoid possible conflicts of interest, an officer or employee of the United States, such as an employee or member of a Uniformed Service, including an employee or staff member of a Uniformed Service legal office, or a CHAMPUS advisor, subject to the exceptions in 18 U.S.C. 205, is not eligible to serve as a representative. An exception usually is made for an employee or member of a Uniformed Service who represents an immediate family member. In addition, the Director, OCHAMPUS, or designee, may appoint an officer or employee of the United States as the OCHAMPUS representative at a hearing.

c. Burden of proof. The burden of proof is on the appealing party to establish affirmatively by substantial evidence the appealing party's entitlement under law and this Regulation to the authorization of the Active Duty Dependents Dental Plan benefits or approval as an authorized provider. Any cost or fee associated with the production or submission of information in support of an appeal may not be paid by OCHAMPUS.

d. Late filing. If a request for reconsideration, formal review, or hearing is filed after the time permitted in this section, written notice shall be issued denying the request. Late filing may be permitted only if the appealing party reasonably can demonstrate to the satisfaction of the dental plan contractor, or the Director, OCHAMPUS, or designee, that timely filing of the request was not feasible due to extraordinary circumstances over which the appealing party had no practical control. Each request for an exception to the filing requirement will be considered on its own merits.

e. Appealable issue. An appealable issue is required in order for an adverse determination to be appealed under the provisions of this section. Examples of issues that are not appealable under this section include:

(1) A dispute regarding a requirement of the law or regulation.

(2) The amount of the dental plan contractor-determined allowable charge since the methodology constitutes a limitation on benefits under the provisions of this part.

(3) Certain other issues on the basis that the authority for the initial determination is not vested in OCHAMPUS. Such issues include but are not limited to the following examples:

(a) Determination of a person's eligibility as an enrolled beneficiary in the Active Duty Dependents Dental Plan is the responsibility of the appropriate Uniformed Service. Although OCHAMPUS and the dental plan contractor must make determinations concerning a beneficiary's enrollment, ultimate responsibility for resolving a beneficiary's eligibility and enrollment rests with the Uniformed Services. Accordingly, a disputed question of fact concerning a beneficiary's enrollment or eligibility will not be considered an appealable issue under the provisions of this section, but shall be resolved in accordance with Section C of this Chapter.

(b) The decision to disqualify or exclude a provider because of a determination against that provider under another Federal or federally funded program is not an initial determination that is appealable under this section. The provider is limited to exhausting administrative appeal rights offered under the Federal or federally funded program that made the initial determination. However, a determination to disqualify or exclude a provider because of abuse or fraudulent practices or procedures under the Active Duty Dependents Dental Plan is an initial determination that is appealable under this section.

f. Amount in dispute. An amount in dispute is required for an adverse determination to be appealed under the provisions of this section, except as set forth in the following.

(1) The amount in dispute is calculated as the amount of money the dental plan contractor would pay if the services and supplies involved in dispute were determined to be authorized benefits of the Active Duty Dependents Dental Plan. Examples of amounts of money that are excluded by this section from payments for authorized benefits include, but are not limited to:

(a) Amounts in excess of the dental plan contractor-determined allowable charge.

(b) The beneficiary's cost-share amounts for restorative services.

(c) Amounts that the beneficiary, or parent, guardian, or other responsible person has no legal obligation to pay.

(2) There is no requirement for an amount in dispute when the appealable issue involves a denial of a provider's request for approval as an authorized provider or the determination to disqualify or exclude a provider as an authorized provider.

(3) Individual claims may be combined to meet the required amount in dispute if all of the following exist:

(a) The claims involve the same beneficiary.

(b) The claims involve the same issue.

(c) At least one of the claims so combined has had a reconsideration decision issued by the dental plan contractor.

NOTE: A request for administrative review under this appeal process which involves a dispute regarding a requirement of law or regulation (paragraph 1.e.(1) of this section) or does not involve a sufficient amount in dispute (paragraph 1.f. of this section) may not be rejected at the reconsideration level of appeal. However, an appeal shall involve an appealable issue and sufficient amount in dispute under these subsections to be granted a formal review or hearing.

g. Levels of appeal. The sequence and procedures of an Active Duty Dependents Dental Plan appeal are contained in the following.

(1) Reconsideration by the dental plan contractor.

(2) Formal review by OCHAMPUS.

(3) Hearing.

2. Reconsideration. Any party to the initial determination made by the dental plan contractor may request a reconsideration.

a. Requesting a reconsideration

(1) Written request required. The request must be in writing, shall state the specific matter in dispute, and shall include a copy of the notice of initial determination made by the dental plan contractor, such as the explanation of benefits.

(2) Where to file. The request shall be submitted to the dental plan contractor's office as designated in the notice of initial determination.

(3) Allowed time to file. The request must be mailed within 90 days after the date of the notice of initial determination.

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(4) Official filing date. A request for a reconsideration shall be deemed filed on the date it is mailed and postmarked. If the request does not have a postmark, it shall be deemed filed on the date received by the dental plan contractor.

b. The reconsideration process. The purpose of the reconsideration is to determine whether the initial determination was made in accordance with law, regulation, policies, and guidelines in effect at the time the care was provided or requested or at the time the provider requested approval as an authorized provider. The reconsideration is performed by a member of the dental plan contractor's staff who was not involved in making the initial determination and is a thorough and independent review of the case. The reconsideration is based on the information submitted that led to the initial determination, plus any additional information that the appealing party may submit or the dental plan contractor may obtain.

c. Timeliness of reconsideration determination. The dental plan contractor normally shall issue its reconsideration determination no later than 60 days from the date of its receipt of the request for reconsideration.

d. Notice of reconsideration determination. The dental plan contractor shall issue a written notice of the reconsideration determination to the appealing party at his or her last known address. The notice of the reconsideration determination must contain the following elements:

(1) A statement of the issue or issues under appeal.

(2) The provisions of law, regulation, policies, and guidelines that apply to the issue or issues under appeal.

(3) A discussion of the original and additional information that is relevant to the issue or issues under appeal.

(4) Whether the reconsideration upholds the initial determination or reverses it, in whole or in part, and the rationale for the action.

(5) A statement of the right to appeal further in any case when the reconsideration determination is less than fully favorable to the appealing party and the amount in dispute is \$50 or more.

e. Effect of reconsideration determination. The reconsideration determination is final if either of the following exist:

(1) The amount in dispute is less than \$50.

(2) Appeal rights have been offered, but a request for formal review is not received by OCHAMPUS within 60 days of the date of the notice of the reconsideration determination.

3. Formal review. Any party to the initial determination may request a formal review by OCHAMPUS if the party is dissatisfied with the reconsideration determination and the reconsideration determination is not final under

the provisions of paragraph 2.e. of this section. Any party to the initial determination made by OCHAMPUS may request a formal review by OCHAMPUS if the party is dissatisfied with the initial determination.

a. Requesting a formal review

(1) Written request required. The request must be in writing, shall state the specific matter in dispute, shall include copies of the written determination (notice of reconsideration determination) being appealed, and shall include any additional information or documents not submitted previously.

(2) Where to file. The request shall be submitted to the Chief, Appeals and Hearings, OCHAMPUS, Aurora, Colorado 80045-6900.

(3) Allowed time to file. The request shall be mailed within 60 days after the date of the notice of the reconsideration determination being appealed.

(4) Official filing date. A request for a formal review shall be deemed filed on the date it is mailed and postmarked. If the request does not have a postmark, it shall be deemed filed on the date received by OCHAMPUS.

b. The formal review process. The purpose of the formal review is to determine whether the initial determination or reconsideration determination was made in accordance with law, regulation, policies, and guidelines in effect at the time the care was provided or requested, at the time the provider requested approval as an authorized provider, or at the time of the action by OCHAMPUS to disqualify or exclude a provider. The formal review is performed by the Chief, Appeals and Hearings, OCHAMPUS, or a designee, and is a thorough review of the case. The formal review determination shall be based on the information upon which the initial determination or reconsideration determination was based and any additional information the appealing party or the dental plan contractor may submit or OCHAMPUS may obtain.

c. Timeliness of formal review determination. The Chief, Appeals and Hearings, OCHAMPUS, or a designee, normally shall issue the formal review determination no later than 90 days from the date of receipt of the request for formal review by the OCHAMPUS.

d. Notice of formal review determination. The Chief, Appeals and Hearings, OCHAMPUS, or a designee, shall issue a written notice of the formal review determination to the appealing party at his or her last known address. The notice of the formal review determination must contain the following elements:

(1) A statement of the issue or issues under appeal.

(2) The provisions of law, regulation, policies, and guidelines that apply to the issue or issues under appeal.

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(3) A discussion of the original and additional information that is relevant to the issue or issues under appeal.

(4) Whether the formal review upholds the prior determination or determinations or reverses the prior determination or determinations in whole or in part and the rationale for the action.

(5) A statement of the right to request a hearing in any case when the formal review determination is less than fully favorable, the issue is appealable, and the amount in dispute is \$300 or more.

e. Effect of formal review determination. The formal review determination is final if one or more of the following exist:

(1) The issue is not appealable. (See paragraph 1.e. of this section.)

(2) The amount in dispute is less than \$300. (See paragraph 1.f. of this section.)

(3) Appeal rights have been offered, but a request for hearing is not received by OCHAMPUS within 60 days of the date of the notice of the formal review determination.

4. Hearing. Any party to the initial determination may request a hearing if the party is dissatisfied with the formal review determination and the formal review determination is not final under the provisions of paragraph 3.e. of this section.

a. Requesting a hearing

(1) Written request required. The request shall be in writing, state the specific matter in dispute, include a copy of the formal review determination, and include any additional information or documents not submitted previously.

(2) Where to file. The request shall be submitted to the Chief, Appeals and Hearings, OCHAMPUS, Aurora, Colorado 80045-6900.

(3) Allowed time to file. The request shall be mailed within 60 days after the date of the notice of the formal review determination being appealed.

(4) Official filing date. A request for hearing shall be deemed filed on the date it is mailed and postmarked. If a request for hearing does not have a postmark, it shall be deemed filed on the date received by OCHAMPUS.

b. The hearing process. The hearing shall be conducted as a nonadversary, administrative proceeding to determine the facts of the case and to allow the appealing party the opportunity personally to present the case before an impartial hearing officer. The hearing is a forum in which facts

relevant to the case are presented and evaluated in relation to applicable law, regulation, policies, and guidelines in effect at the time the care was provided or requested, or at the time the provider requested approval as an authorized provider.

c. Timeliness of hearing

(1) Except as otherwise provided in this section, within 60 days following receipt of a request for hearing, the Director, OCHAMPUS, or a designee, normally will appoint a hearing officer to hear the appeal. Copies of all records in the possession of OCHAMPUS that are pertinent to the matter to be heard or that formed the basis of the formal review determination shall be provided to the hearing officer and, upon request, to the appealing party.

(2) The hearing officer, except as otherwise provided in this section, normally shall have 60 days from the date of written notice of assignment to review the file, schedule and hold the hearing, and issue a recommended decision to the Director, OCHAMPUS, or designee.

(3) The Director, OCHAMPUS, or designee, may delay the case assignment to the hearing officer if additional information is needed that cannot be obtained and included in the record within the time period specified above. The appealing party will be notified in writing of the delay resulting from the request for additional information. The Director, OCHAMPUS, or a designee, in such circumstances, will assign the case to a hearing officer within 30 days of receipt of all such additional information or within 60 days of receipt of the request for hearing, whichever shall occur last.

(4) The hearing officer may delay submitting the recommended decision if, at the close of the hearing, any party to the hearing requests that the record remain open for submission of additional information. In such circumstances, the hearing officer will have 30 days following receipt of all such additional information including comments from the other parties to the hearing concerning the additional information to submit the recommended decision to the Director, OCHAMPUS, or a designee.

d. Representation at a hearing. Any party to the hearing may appoint a representative to act on behalf of the party at the hearing, unless such person currently is disqualified or suspended from acting in another Federal administrative proceeding, or unless otherwise prohibited by law, this part, or any other DoD regulation (see paragraph 1 of this section). A hearing officer may refuse to allow any person to represent a party at the hearing when such person engages in unethical, disruptive, or contemptuous conduct, or intentionally fails to comply with proper instructions or requests of the hearing officer or the provisions of this part. The representative shall have the same authority as the appealing party, and notice given to the representative shall constitute notice required to be given to the appealing party.

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e. Consolidation of proceedings. The Director, OCHAMPUS, or a designee, may consolidate any number of proceedings for hearing when the facts and circumstances are similar and no substantial right of an appealing party will be prejudiced.

f. Authority of the hearing officer. The hearing officer, in exercising the authority to conduct a hearing under this part, will be bound by 10 U.S.C., Chapter 55 and this part. The hearing officer in addressing substantive, appealable issues shall be bound by the dental benefits brochure, policies, procedures, and other guidelines issued by the ASD(HA), or a designee, or by the Director, OCHAMPUS, or a designee, in effect for the period in which the matter in dispute arose. A hearing officer may not establish or amend the dental benefits brochure, policy, procedures, instructions, or guidelines. However, the hearing officer may recommend reconsideration of the policy, procedures, instructions or guidelines by the ASD(HA), or a designee, when the final decision is issued in the case.

g. Disqualification of hearing officer. A hearing officer voluntarily shall disqualify himself or herself and withdraw from any proceeding in which the hearing officer cannot give fair or impartial hearing, or in which there is a conflict of interest. A party to the hearing may request the disqualification of a hearing officer by filing a statement detailing the reasons the party believes that a fair and impartial hearing cannot be given or that a conflict of interest exists. Such request immediately shall be sent by the appealing party or the hearing officer to the Director, OCHAMPUS, or a designee, who shall investigate the allegations and advise the complaining party of the decision in writing. A copy of such decision also shall be mailed to all other parties to the hearing. If the Director, OCHAMPUS, or a designee, reassigns the case to another hearing officer, no investigation shall be required.

h. Notice and scheduling of hearing. The hearing officer shall issue by certified mail, when practicable, a written notice to the parties to the hearing of the time and place for the hearing. Such notice shall be mailed at least 15 days before the scheduled date of the hearing. The notice shall contain sufficient information about the hearing procedure, including the party's right to representation, to allow for effective preparation. The notice also shall advise the appealing party of the right to request a copy of the record before the hearing. Additionally, the notice shall advise the appealing party of his or her responsibility to furnish the hearing officer, no later than 7 days before the scheduled date of the hearing, a list of all witnesses who will testify and a copy of all additional information to be presented at the hearing. The time and place of the hearing shall be determined by the hearing officer, who shall select a reasonable time and location mutually convenient to the appealing party and OCHAMPUS.

i. Dismissal of request for hearing

(1) By application of appealing party. A request for hearing may be dismissed by the Director, OCHAMPUS, or a designee, at any time before the mailing of the final decision, upon the application of the appealing party. A request for dismissal must be in writing and filed with the Chief.

appeals and Hearings, OCHAMPUS, or the hearing officer. When dismissal is requested, the formal review determination in the case shall be deemed final, unless the dismissal is vacated in accordance with subparagraph (5) below.

(2) By stipulation of the parties to the hearing. A request for a hearing may be dismissed by the Director, OCHAMPUS, or a designee, at any time before the mailing of notice of the final decision under a stipulation agreement between the appealing party and OCHAMPUS. When dismissal is entered under a stipulation, the formal review decision shall be deemed final, unless the dismissal is vacated in accordance with subparagraph (5) below.

(3) By abandonment. The Director, OCHAMPUS, or a designee, may dismiss a request for hearing upon abandonment by the appealing party.

(a) An appealing party shall be deemed to have abandoned a request for hearing, other than when personal appearance is waived in accordance with paragraph 4.k.(13), below, if neither the appealing party nor an appointed representative appears at the time and place fixed for the hearing and if, within 10 days after the mailing of a notice by certified mail to the appealing party by the hearing officer to show cause, such party does not show good and sufficient cause for such failure to appear and failure to notify the hearing officer before the time fixed for hearing that an appearance could not be made.

(b) An appealing party shall be deemed to have abandoned a request for hearing if, before assignment of the case to the hearing officer, OCHAMPUS is unable to locate either the appealing party or an appointed representative.

(c) An appealing party shall be deemed to have abandoned a request for hearing if the appealing party fails to prosecute the appeal. Failure to prosecute the appeal includes, but is not limited to, an appealing party's failure to provide information reasonably requested by OCHAMPUS or the hearing officer for consideration in the appeal.

(d) If the Director, OCHAMPUS, or a designee, dismisses the request for hearing because of abandonment, the formal review determination in the case shall be deemed to be final, unless the dismissal is vacated in accordance with paragraph 4.i.(5) below.

(4) For cause. The Director, OCHAMPUS, or a designee, may dismiss for cause a request for hearing either entirely or as to any stated issue. If the Director, OCHAMPUS, or a designee, dismisses a hearing request for cause, the formal review determination in the case shall be deemed to be final, unless the dismissal is vacated in accordance with paragraph 4.i.(5) below. A dismissal for cause may be issued under any of the following circumstances:

(a) When the appealing party requesting the hearing is not a proper party under paragraph 1.b.(1), above, or does not otherwise have a right to participate in a hearing.

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(b) When the appealing party who filed the hearing request dies, and there is no information before the Director, OCHAMPUS, or a designee, showing that a party to the initial determination who is not an appealing party may be prejudiced by the formal review determination.

(c) When the issue is not appealable (See paragraph 1.e. of this section.)

(d) When the amount in dispute is less than \$300 (See paragraph 1.f. of this section.)

(e) When all appealable issues have been resolved in favor of the appealing party.

(5) Vacation of dismissal. Dismissal of a request for hearing may be vacated by the Director, OCHAMPUS, or a designee, upon written request of the appealing party, if the request is received within 6 months of the date of the notice of dismissal mailed to the last known address of the party requesting the hearing.

j. Preparation for hearing

(1) Prehearing statement of contentions. The hearing officer may on reasonable notice, require a party to the hearing to submit a written statement of contentions and reasons. The written statement shall be provided to all parties to the hearing before the hearing takes place.

(2) Agency records

(a) Hearing officer. A hearing officer may ask OCHAMPUS to produce, for inspection, any records or relevant portions of records when they are needed to decide the issues in any proceeding before the hearing officer or to assist an appealing party in preparing for the proceeding.

(b) Appealing party. A request to a hearing officer by an appealing party for disclosure or inspection of OCHAMPUS or the dental plan contractor records shall be in writing and shall state clearly what information and records are required.

(3) Witnesses and evidence. All parties to a hearing are responsible for producing, at each party's expense, meaning without reimbursement of payment by OCHAMPUS, witnesses and other evidence in their own behalf, and for furnishing copies of any such documentary evidence to the hearing officer and other party or parties to the hearing. The Department of Defense is not authorized to subpoena witnesses or records. The hearing officer may issue invitations and requests to individuals to appear and testify without cost to the Government, so that the full facts in the case may be presented.

(4) Interrogatories and depositions. A hearing officer may arrange to take interrogatories and depositions, recognizing that the Department of Defense does not have subpoena authority. The expense shall be

assessed to the requesting party, with copies furnished to the hearing officer and other party or parties to the hearing.

k. Conduct of hearing

(1) Right to open hearing. Because of the personal nature of the matters to be considered, hearings normally shall be closed to the public. However, the appealing party may request an open hearing. If this occurs, the hearing shall be open, except when protection of other legitimate Government purposes dictates closing certain portions of the hearing.

(2) Right to examine parties to the hearing and their witnesses. Each party to the hearing shall have the right to produce and examine witnesses, to introduce exhibits, to question opposing witnesses on any matter relevant to the issue even though the matter was not covered in the direct examination, to impeach any witness regardless of which party to the hearing first called the witness to testify, and to rebut any evidence presented. Except for those witnesses employed by OCHAMPUS at the time of the hearing or records in the possession of OCHAMPUS, a party to a hearing shall be responsible, that is to say no payment or reimbursement shall be made by CHAMPUS for the cost or fee associated with producing witnesses or other evidence in the party's own behalf, or for furnishing copies of documentary evidence to the hearing officer and other party or parties to the hearing.

(3) Burden of proof. The burden of proof is on the appealing party affirmatively to establish by substantial evidence the appealing party's entitlement under law and this Regulation to the authorization of Active Duty Dependents Dental Plan benefits or approval as an authorized provider. Any part of the cost or fee associated with producing or submitting in support of an appeal may not be paid by OCHAMPUS.

(4) Taking of evidence. The hearing officer shall control the taking of evidence in a manner best suited to ascertain the facts and safeguard the rights of the parties to the hearing. Before taking evidence, the hearing officer shall identify and state the issues in dispute on the record and the order in which evidence will be received.

(5) Questioning and admission of evidence. A hearing officer may question any witness and shall admit any relevant evidence. Evidence that is irrelevant or unduly repetitious shall be excluded.

(6) Relevant evidence. Any relevant evidence shall be admitted, unless unduly repetitious, if it is the type of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule that might make improper the admission of such evidence over objection in civil or criminal actions.

(7) Active Duty Dependents Dental Plan determination first. The basis of the Active Duty Dependents Dental Plan determinations shall be presented to the hearing officer first. The appealing party shall then be given the opportunity to establish affirmatively why this determination is held to be in error.

(8) Testimony. Testimony shall be taken only on oath, affirmation, or penalty of perjury.

(9) Oral argument and briefs. At the request of any party to the hearing made before the close of the hearing, the hearing officer shall grant oral argument. If written argument is requested, it shall be granted, and the parties to the hearing shall be advised as to the time and manner within which such argument is to be filed. The hearing officer may require any party to the hearing to submit written memoranda pertaining to any or all issues raised in the hearing.

(10) Continuance of hearing. A hearing officer may continue a hearing to another time or place on his or her own motion or, upon showing of good cause, at the request of any party. Written notice of the time and place of the continued hearing, except as otherwise provided here, shall be in accordance with this part. When a continuance is ordered during a hearing, oral notice of the time and place of the continued hearing may be given to each party to the hearing who is present at the hearing.

(11) Continuance for additional evidence. If the hearing officer determines, after a hearing has begun, that additional evidence is necessary for the proper determination of the case, the following procedures may be invoked:

(a) Continue hearing. The hearing may be continued to a later date in accordance with paragraph 4.k.(10) of this section.

(b) Closed hearing. The hearing may be closed, but the record held open in order to permit the introduction of additional evidence. Any evidence submitted after the close of the hearing shall be made available to all parties to the hearing, and all parties to the hearing shall have the opportunity for comment. The hearing officer may reopen the hearing if any portion of the additional evidence makes further hearing desirable. Notice thereof shall be given in accordance with paragraph 4.h. of this section.

(12) Transcript of hearing. A verbatim taped record of the hearing shall be made and shall become a permanent part of the record. Upon request, the appealing party shall be furnished a duplicate copy of the tape. A typed transcript of the testimony will be made only when determined to be necessary by OCHAMPUS. If a typed transcript is made, the appealing party shall be furnished a copy without charge. Corrections shall be allowed in the typed transcript by the hearing officer solely for the purpose of conforming the transcript to the actual testimony.

(13) Waiver of right to appear and present evidence. If all parties waive their right to appear before the hearing officer for presenting evidence and contentions personally or by representation, it will not be necessary for the hearing officer to give notice of, or to conduct a formal hearing. A waiver of the right to appear must be in writing and filed with the hearing officer or the Chief, Appeals and Hearings, OCHAMPUS. Such

waiver may be withdrawn by the party by written notice received by the hearing officer or Chief, Appeals and Hearings, no later than 7 days before the scheduled hearing or the mailing of notice of the final decision, whichever occurs first. For purposes of this section, failure of a party to appear personally or by representation after filing written notice of waiver, will not be cause for finding of abandonment and the hearing officer shall make the recommended decision on the basis of all evidence of record.

(14) Recommended decision. At the conclusion of the hearing and after the record has been closed, the matter shall be taken under consideration by the hearing officer. Within the time frames previously set forth in this section, the hearing officer shall submit to the Director, OCHAMPUS, or a designee, a written recommended decision containing a statement of findings and a statement of reasons based on the evidence adduced at the hearing and otherwise included in the hearing record.

(a) Statement of findings. A statement of findings is a clear and concise statement of fact evidenced in the record or conclusions that readily can be deduced from the evidence of record. Each finding must be supported by substantial evidence that is defined as such evidence as a reasonable mind can accept as adequate to support a conclusion.

(b) Statement of reasons. A reason is a clear and concise statement of law, regulation, policies, or guidelines relating to the statement of findings that provides the basis for the recommended decision.

5. Final decision

a. Director, OCHAMPUS. The recommended decision shall be reviewed by the Director, OCHAMPUS, or a designee, who shall adopt or reject the recommended decision or refer the recommended decision for review by the Assistant Secretary of Defense (Health Affairs). The Director, OCHAMPUS, or designee, normally will take action with regard to the recommended decision within 90 days of receipt of the recommended decision or receipt of the revised recommended decision following a remand order to the Hearing Officer.

(1) Final action. If the Director, OCHAMPUS, or a designee, concurs in the recommended decision, no further agency action is required and the recommended decision, as adopted by the Director, OCHAMPUS, is the final agency decision in the appeal. In the case of rejection, the Director, OCHAMPUS, or a designee, shall state the reason for disagreement with the recommended decision and the underlying facts supporting such disagreement. In these circumstances, the Director, OCHAMPUS, or a designee, may have a final decision prepared based on the record, or may remand the matter to the Hearing Officer for appropriate action. In the latter instance, the Hearing Officer shall take appropriate action and submit a new recommended decision within 60 days of receipt of the remand order. The decision by the Director, OCHAMPUS, or a designee, concerning a case arising under the procedures of this section, shall be the final agency decision and the final decision shall be sent by certified mail to the appealing party or parties. A final agency decision under this paragraph 5.a. will not be relied on, used, or cited as precedent by the Department of Defense or the dental plan contractor in the administration of the Active Duty Dependents Dental Plan.

(2) Referral for review by ASD(HA). The Director, OCHAMPUS, or a designee, may refer a hearing case to the Assistant Secretary of Defense (Health Affairs) when the hearing involves the resolution of policy and issuance of a final decision which may be relied on, used, or cited as precedent in the administration of the Active Duty Dependents Dental Plan. In such a circumstance, the Director, OCHAMPUS, or a designee, shall forward the recommended decision, together with the recommendation of the Director, OCHAMPUS, or a designee, regarding disposition of the hearing case.

b. ASD(HA). The ASD(HA), or a designee, after reviewing a case arising under the procedures of this section may issue a final decision based on the record in the hearing case or remand the case to the Director, OCHAMPUS, or a designee, for appropriate action. A decision issued by the ASD(HA), or a designee, shall be the final agency decision in the appeal and a copy of the final decision shall be sent by certified mail to the appealing party or parties. A final decision of the ASD(HA), or a designee, issued under this paragraph 5.b. may be relied on, used, or cited as precedent in the administration of the Active Duty Dependents Dental Plan.

CHAPTER 14

PROVIDER REIMBURSEMENT METHODS

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CHAPTER 14
PROVIDER REIMBURSEMENT METHODS

A. HOSPITALS

The CHAMPUS-determined allowable cost for reimbursement of a hospital shall be determined on the basis of one of the following methodologies.

1. CHAMPUS Diagnosis Related Group (DRG)-based payment system. Under the CHAMPUS DRG-based payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system is made on the basis of prospectively-determined rates and applied on a per discharge basis using DRGs. Payments under this system will include a differentiation for urban (using large urban and other urban areas) and rural hospitals and an adjustment for area wage differences and indirect medical education costs. Additional payments will be made for capital costs, direct medical education costs, and outlier cases.

a. General.

(1) DRGs used. The CHAMPUS DRG-based payment system will use the same DRGs used in the most recently available grouper for the Medicare Prospective Payment System, except as necessary to recognize distinct characteristics of CHAMPUS beneficiaries and as described in instructions issued by the Director, OCHAMPUS.

(2) Assignment of discharges to DRGs.

(a) The classification of a particular discharge shall be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed and discharge status. In addition, for neonatal cases (other than normal newborns) the classification shall also account for birthweight, surgery and the presence of multiple, major and other neonatal problems, and shall incorporate annual updates to these classification features.

(b) Each discharge shall be assigned to only one DRG regardless of the number of conditions treated or services furnished during the patient's stay.

(3) Basis of payment.

(a) Hospital billing. Under the CHAMPUS DRG-based payment system, hospitals are required to submit claims (including itemized charges) in accordance with section B. of Chapter 7. The CHAMPUS fiscal intermediary will assign the appropriate DRG to the claim based on the information contained on the claim.

(b) Payment on a per discharge basis. Under the CHAMPUS DRG-based payment system, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to CHAMPUS beneficiaries.

(c) Claims priced as of date of admission. Except for interim claims submitted for qualifying outlier cases, all claims reimbursed under the CHAMPUS DRG-based payment system are to be priced as of the date of admission, regardless of when the claim is submitted.

(d) Payment in full. The DRG-based amount paid for inpatient hospital services is the total CHAMPUS payment for the inpatient operating costs (as described in subparagraph A.1.a.(3)(e)) incurred in furnishing services covered by the CHAMPUS. The full prospective payment amount is payable for each stay during which there is at least one covered day of care, except as provided in subparagraph A.1.c.(5)(a)1a.

(e) Inpatient operating costs. The CHAMPUS DRG-based payment system provides a payment amount for inpatient operating costs, including:

1 Operating costs for routine services; such as the costs of room, board, and routine nursing services;

2 Operating costs for ancillary services, such as hospital radiology and laboratory services (other than physicians' services) furnished to hospital inpatients;

3 Special care unit operating costs; and

4 Malpractice insurance costs related to services furnished to inpatients.

(f) Discharges and transfers.

1 Discharges. A hospital inpatient is discharged when:

a The patient is formally released from the hospital (release of the patient to another hospital as described in subparagraph 2 of this subparagraph, or a leave of absence from the hospital, will not be recognized as a discharge for the purpose of determining payment under the CHAMPUS DRG-based payment system);

b The patient dies in the hospital; or

c The patient is transferred from the care of a hospital included under the CHAMPUS DRG-based payment system to a hospital or unit that is excluded from the prospective payment system.

2 Transfers. Except as provided under subparagraph A.1.a.(3)(f)1, a discharge of a hospital inpatient is not counted for purposes of the CHAMPUS DRG-based payment system when the patient is transferred:

a From one inpatient area or unit of the hospital to another area or unit of the same hospital;

b From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of another hospital paid under this system;

c From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of another hospital that is excluded from the CHAMPUS DRG-based payment system because of participation in a statewide cost control program which is exempt from the CHAMPUS DRG-based payment system under subparagraph A.1.b.(1) of this chapter; or

d From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of a uniformed services treatment facility.

3 Payment in full to the discharging hospital.
The hospital discharging an inpatient shall be paid in full under the CHAMPUS DRG-based payment system.

4 Payment to a hospital transferring an inpatient to another hospital. If a hospital subject to the CHAMPUS DRG-based payment system transfers an inpatient to another such hospital, the transferring hospital shall be paid a per diem rate (except that in neonatal cases, other than normal newborns, the hospital will be paid at 125 percent of that per diem rate), as determined under instructions issued by OCHAMPUS, for each day of the patient's stay in that hospital, not to exceed the DRG-based payment that would have been paid if the patient had been discharged to another setting. However, if a discharge is classified into DRG No. 456 (Burns, transferred to another acute care facility) or DRG 601 (neonate, transferred less than or equal to 4 days old), the transferring hospital shall be paid in full.

5 Additional payments to transferring hospitals.
A transferring hospital may qualify for an additional payment for extraordinary cases that meet the criteria for long-stay or cost outliers.

b. Applicability of the DRG system.

(1) Areas affected. The CHAMPUS DRG-based payment system shall apply to hospitals' services in the fifty states, the District of Columbia, and Puerto Rico, except that any state which has implemented a separate DRG-based payment system or similar payment system in order to control costs and is exempt from the Medicare Prospective Payment System may be exempt from the CHAMPUS DRG-based payment system if it requests exemption in writing, and provided payment under such system does not exceed payment which would otherwise be made under the CHAMPUS DRG-based payment system.

(2) Services subject to the DRG-based payment system. All normally covered inpatient hospital services furnished to CHAMPUS beneficiaries by hospitals are subject to the CHAMPUS DRG-based payment system.

(3) Services exempt from the DRG-based payment system. The following hospital services, even when provided in a hospital subject to the CHAMPUS DRG-based payment system, are exempt from the CHAMPUS DRG-based payment system. The services in subparagraphs A.1.b.(3)(a) through (d) and (g) through (i) shall be reimbursed under the procedures in subsection A.3. of this chapter, and the services in subparagraphs A.1.b.(3)(e) and (f) shall be reimbursed under the procedures in section G. of this chapter.

(a) Services provided by hospitals exempt from the DRG-based payment system.

(b) All services related to kidney acquisition by Renal Transplantation Centers.

(c) All services related to a heart transplantation which would otherwise be paid under DRG 103.

(d) All services related to liver transplantation when the transplant is performed in a CHAMPUS-authorized liver transplantation center.

(e) All professional services provided by hospital-based physicians.

(f) All services provided by nurse anesthetists.

(g) All services related to discharges involving pediatric bone marrow transplants (patient under 18 at admission).

(h) All services related to discharges involving children who have been determined to be HIV seropositive (patient under 18 at admission).

(i) All services related to discharges involving pediatric cystic fibrosis (patient under 18 at admission).

(4) Hospitals subject to the CHAMPUS DRG-based payment system. All hospitals within the fifty states, the District of Columbia, and Puerto Rico which are certified to provide services to CHAMPUS beneficiaries are subject to the DRG-based payment system except for the following hospitals or hospital units which are exempt.

(a) Psychiatric hospitals. A psychiatric hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS DRG-based payment system. In order for a psychiatric hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in Section 412.23 of Title 42 CFR.

(b) Rehabilitation hospitals. A rehabilitation hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS DRG-based payment system. In order for a rehabilitation hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in Section 412.23 of Title 42 CFR.

(c) Psychiatric and rehabilitation units (distinct parts). A psychiatric or rehabilitation unit which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a distinct unit which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in Section 412.23 of Title 42 CFR.

(d) Long-term hospitals. A long-term hospital which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a long-term hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must have an average length of inpatient stay greater than 25 days:

1 As computed by dividing the number of total inpatient days (less leave or pass days) by the total number of discharges for the hospital's most recent fiscal year; or

2 As computed by the same method for the immediately preceding six-month period, if a change in the hospital's average length of stay is indicated.

(e) Sole community hospitals. Any hospital which has qualified for special treatment under the Medicare prospective payment system as a sole community hospital and has not given up that classification is exempt from the CHAMPUS DRG-based payment system. (See Subpart G of 42 CFR Part 412.)

(f) Christian Science sanitoriums. All Christian Science sanitoriums (as defined in paragraph B.4.h. of Chapter 6) are exempt from the CHAMPUS DRG-based payment system.

(g) Cancer hospitals. Any hospital which qualifies as a cancer hospital under the Medicare standards and has elected to be exempt from the Medicare prospective payment system is exempt from the CHAMPUS DRG-based payment system. (See 42 CFR Section 412.94.)

(h) Hospitals outside the 50 states, the District of Columbia, and Puerto Rico. A hospital is excluded from the CHAMPUS DRG-based payment system if it is not located in one of the fifty States, the District of Columbia, or Puerto Rico.

(5) Hospitals which do not participate in Medicare. It is not required that a hospital be a Medicare-participating provider in order to be an authorized CHAMPUS provider. However, any hospital which is subject to the CHAMPUS DRG-based payment system and which otherwise meets CHAMPUS requirements but which is not a Medicare-participating provider (having completed a form HCFA-1514, Hospital Request for Certification in the Medicare/Medicaid Program and a form HCFA-1561, Health Insurance Benefit Agreement) must complete a participation agreement with OCHAMPUS. By completing the participation agreement, the hospital agrees to participate on all CHAMPUS inpatient claims and to accept the CHAMPUS-determined allowable amount as payment in full for these claims. Any hospital which does not participate in Medicare and does not complete a participation agreement with OCHAMPUS will not be authorized to provide services to CHAMPUS beneficiaries.

c. Determination of payment amounts. The actual payment for an individual claim under the CHAMPUS DRG-based payment system is calculated by multiplying the appropriate adjusted standardized amount (adjusted to account for area wage differences using the wage indexes used in the Medicare program) by a weighting factor specific to each DRG.

(1) Calculation of DRG Weights.

(a) Grouping of charges. All discharge records in the database shall be grouped by DRG.

(b) Remove DRGs 469 and 470. Records from DRGs 469 and 470 shall be removed from the database.

(c) Indirect medical education standardization. To standardize the charges for the cost effects of indirect medical education factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.43 \times 1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \times .5795 - 1.0$$

(d) Wage level standardization. To standardize the charge records for area wage differences, each charge record will be divided into labor-related and nonlabor-related portions, and the labor-related portion shall be divided by the most recently available Medicare wage index for the area. The labor-related and nonlabor-related portions will then be added together.

(e) Elimination of statistical outliers. All unusually high or low charges shall be removed from the database

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(f) Calculation of DRG average charge. After the standardization for indirect medical education, and area wage differences, an average charge for each DRG shall be computed by summing charges in a DRG and dividing that sum by the number of records in the DRG.

(g) Calculation of national average charge per discharge. A national average charge per discharge shall be calculated by summing all charges and dividing that sum by the total number of records from all DRG categories.

(h) DRG relative weights. DRG relative weights shall be calculated for each DRG category by dividing each DRG average charge by the national average charge.

(2) Empty and low-volume DRGs. The Medicare weight shall be used for any DRG with less than ten (10) occurrences in the CHAMPUS database. The short-stay thresholds shall be set at one day for these DRGs and the long-stay thresholds shall be set at the FY 87 Medicare thresholds.

(3) Updating DRG weights. The CHAMPUS DRG weights shall be updated or adjusted as follows:

(a) DRG weights shall be recalculated annually using CHAMPUS charge data and the methodology described in subparagraph A.1.c.(1) of this chapter.

(b) When a new DRG is created, CHAMPUS will, if practical, calculate a weight for it using an appropriate charge sample (if available) and the methodology described in subparagraph A.1.c.(1) of this chapter.

(c) In the case of any other change under Medicare to an existing DRG weight (such as in connection with technology changes), CHAMPUS shall adjust its weight for that DRG in a manner comparable to the change made by Medicare.

(4) Calculation of the adjusted standardized amounts. The following procedures shall be followed in calculating the CHAMPUS adjusted standardized amounts.

(a) Differentiate large urban, other urban, and rural charges. All charges in the database shall be sorted into large urban, other urban, and rural groups (using the same definitions for these categories used in the Medicare program). The following procedures will be applied to each group.

(b) Indirect medical education standardization. To standardize the charges for the cost effects of indirect medical education

factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.43 \times 1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \cdot .5795 - 1.0$$

(c) Wage level standardization. To standardize the charge records for area wage differences, each charge record will be divided into labor-related and nonlabor-related portions, and the labor-related portion shall be divided by the most recently available Medicare wage index for the area. The labor-related and nonlabor-related portions will then be added together.

(d) Apply the cost to charge ratio. Each charge is to be reduced to a representative cost by using the Medicare cost to charge ratio. This amount shall be increased by 1 percentage point in order to reimburse hospitals for bad debt expenses attributable to CHAMPUS beneficiaries.

(e) Preliminary base year standardized amount. A preliminary base year standardized amount shall be calculated by summing all costs in the database applicable to the large urban, other urban, or rural group and dividing by the total number of discharges in the respective group.

(f) Update for inflation. The preliminary base year standardized amounts shall be updated using an annual update factor equal to 1.07 to produce fiscal year 1988 preliminary standardized amounts. Thereafter, any development of a new standardized amount will use an inflation factor equal to the hospital market basket index used by the Health Care Financing Administration in their Prospective Payment System.

(g) The preliminary standardized amounts, updated for inflation, shall be divided by a system standardization factor so that total DRG outlays, given the database distribution across hospitals and diagnoses, are equal to the total charges reduced to costs.

(h) Labor and nonlabor portions of the adjusted standardized amounts. The adjusted standardized amounts shall be divided into labor and nonlabor portions in accordance with the Medicare division of labor and nonlabor portions.

(5) Adjustments to the DRG-based payment amounts. The following adjustments to the DRG-based amounts (the weight multiplied by the adjusted standardized amount) will be made.

(a) Outliers. The DRG-based payment to a hospital shall be adjusted for atypical cases. These outliers are those cases that have either an unusually short length-of-stay or extremely long length-of-stay or

that involve extraordinarily high costs when compared to most discharges classified in the same DRG. Cases which qualify as both a length-of-stay outlier and a cost outlier shall be paid at the rate which results in the greater payment.

1 Length-of-stay outliers. Length-of-stay outliers shall be identified and paid by the fiscal intermediary when the claims are processed.

a Short-stay outliers. Any discharge with a length-of-stay (LOS) less than 1.94 standard deviations from the DRG's geometric LOS shall be classified as a short-stay outlier. Short-stay outliers shall be reimbursed at 200 percent of the per diem rate for the DRG for each covered day of the hospital stay, not to exceed the DRG amount. The per diem rate shall equal the DRG amount divided by the geometric mean length-of-stay for the DRG.

b Long-stay outliers. Any discharge which has a length-of-stay (LOS) exceeding the lesser of 3.00 standard deviations or 24 days (1.94 standard deviations or 17 days for neonate services and for services in children's hospitals) from the DRG's geometric mean LOS shall be classified as a long-stay outlier. Long-stay outliers shall be reimbursed the DRG-based amount plus 60 percent (90 percent for DRGs related to burn cases) of the per diem rate for the DRG for each covered day of care beyond the long-stay outlier cutoff. The per diem rate shall equal the DRG amount divided by the geometric mean LOS for the DRG.

2 Cost outliers. Any discharge which has standardized costs that exceed a threshold of the greater of two times the DRG-based amount or \$28,000 (\$13,500 for neonate services and for services in children's hospitals) shall qualify as a cost outlier. The standardized costs shall be calculated by multiplying the total charges by the factor described in subparagraph A.1.c.(4)(d) and adjusting this amount for indirect medical education costs. Cost outliers shall be reimbursed the DRG-based amount plus 75 percent (90 percent for DRGs related to burn cases and 80 percent for neonatal services and for services in children's hospitals) of all costs exceeding the threshold. Additional payment for cost outliers shall be made only upon request by the hospital. Notwithstanding the threshold amount stated in the first sentence of this subparagraph and the marginal payment percentage stated in the third sentence of this subparagraph, for all discharges to patients admitted prior to November 21, 1988, a threshold amount of \$13,500 (rather than \$28,000) shall apply and (except for burn cases, neonatal services and services in children's hospitals) a marginal payment percentage of 60 percent (rather than 75 percent) shall apply.

(b) Wage Adjustment. CHAMPUS will adjust the labor portion of the standardized amounts according to the hospital's area wage index.

(c) Indirect Medical Education Adjustment. The wage adjusted DRG payment will also be multiplied by 1.0 plus the hospital's indirect medical education ratio.

(d) Children's Hospital Differential. With respect to claims from children's hospitals, the appropriate adjusted standardized amount shall also be adjusted by a children's hospital differential.

1 Qualifying children's hospitals. Hospitals qualifying for the children's hospital differential are hospitals that are exempt from the Medicare Prospective Payment System, or, in the case of hospitals that do not participate in Medicare, that meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in 42 CFR 412.23.

2 Calculation of differential. The differential shall be equal to the difference between a specially calculated children's hospital adjusted standardized amount and the adjusted standardized amount for fiscal year 1988. The specially calculated children's hospital adjusted standardized amount shall be calculated in the same manner as set forth in subparagraph A.1.c.(4), except that:

a The base period shall be fiscal year 1988 and shall represent total estimated charges for discharges that occurred during fiscal year 1988.

b No cost to charge ratio shall be applied.

c Capital costs and direct medical education costs will be included in the calculation.

d The factor used to update the database for inflation to produce the fiscal year 1988 base period amount shall be the applicable Medicare inpatient hospital market basket rate.

3 Transition rule. Until March 1, 1992, separate differentials shall be used for each higher volume children's hospital (individually) and for all other children's hospitals (in the aggregate). For this purpose, a higher volume hospital is a hospital that had 50 or more CHAMPUS discharges in fiscal year 1988.

4 Hold harmless provision. At such time as the weights initially assigned to neonatal DRGs are recalibrated based on sufficient volume of CHAMPUS claims records, children's hospital differentials shall be recalculated and appropriate retrospective and prospective adjustments shall be made. To the extent practicable, the recalculation shall also include reestimated values of other factors (including but not limited to direct education and capital costs and indirect education factors) for which more accurate data became available.

5 No update for inflation. The children's hospital differential, calculated (and later recalculated under the hold harmless provision) for the base period of fiscal year 1988, shall not be updated for subsequent fiscal years.

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6 Administrative corrections. In connection with determinations pursuant to subparagraph A.1.c.(5)(d)3 of this chapter, any children's hospital that believes OCHAMPUS erroneously failed to classify the hospital as a high volume hospital or incorrectly calculated (in the case of a high volume hospital) the hospital's differential may obtain administrative corrections by submitting appropriate documentation to the Director, OCHAMPUS (or designee).

(6) Updating the adjusted standardized amounts. Beginning in FY 1989, the adjusted standardized amounts will be updated by the Medicare annual update factor, unless the adjusted standardized amounts are recalculated.

(7) Annual Cost Pass-Throughs.

(a) Capital costs. When requested in writing by a hospital, CHAMPUS shall reimburse the hospital its share of actual capital costs as reported annually to the CHAMPUS fiscal intermediary. Payment for capital costs shall be made annually based on the ratio of CHAMPUS inpatient days for those beneficiaries subject to the CHAMPUS DRG-based payment system to total inpatient days applied to the hospital's total allowable capital costs. Reductions in payments for capital costs which are required under Medicare shall also be applied to payments for capital costs under CHAMPUS.

1 Costs included as capital costs. Allowable capital costs are those specified in Medicare Regulation Section 413.130, as modified by Section 412.72.

2 Services, facilities, or supplies provided by supplying organizations. If services, facilities, or supplies are provided to the hospital by a supplying organization related to the hospital within the meaning of Medicare Regulation Section 413.17, then the hospital must include in its capital-related costs, the capital-related costs of the supplying organization. However, if the supplying organization is not related to the provider within the meaning of 413.17, no part of the charge to the provider may be considered a capital-related cost unless the services, facilities, or supplies are capital-related in nature and:

a The capital-related equipment is leased or rented by the provider;

b The capital-related equipment is located on the provider's premises; and

c The capital-related portion of the charge is separately specified in the charge to the provider.

(b) Direct medical education costs. When requested in writing by a hospital, CHAMPUS shall reimburse the hospital its actual direct medical education costs as reported annually to the CHAMPUS fiscal intermediary. Such teaching costs must be for a teaching program approved

under Medicare Regulation Section 413.85. Payment for direct medical education costs shall be made annually based on the ratio of CHAMPUS inpatient days for those beneficiaries subject to the CHAMPUS DRG-based payment system to total inpatient days applied to the hospital's total allowable direct medical education costs. Allowable direct medical education costs are those specified in Medicare Regulation Section 413.85.

(c) Information necessary for payment of capital and direct medical education costs. All hospitals subject to the CHAMPUS DRG-based payment system, except for children's hospitals, may be reimbursed for allowed capital and direct medical education costs by submitting a request to the CHAMPUS contractor. Such request shall cover the one-year period corresponding to the hospital's Medicare cost-reporting period. The first such request may cover a period of less than a full year--from the effective date of the CHAMPUS DRG-based payment system to the end of the hospital's Medicare cost-reporting period. All costs reported to the CHAMPUS contractor must correspond to the costs reported on the hospital's Medicare cost report. In the case of children's hospitals that request reimbursement under this clause for capital and/or direct medical education costs, the hospital must submit appropriate base period cost information, as determined by the Director, OCHAMPUS (or designee). (If these costs change as a result of a subsequent audit by Medicare, the revised costs are to be reported to the hospital's CHAMPUS contractor within 30 days of the date the hospital is notified of the change.) The request must be signed by the hospital official responsible for verifying the amounts and shall contain the following information.

- 1 The hospital's name.
- 2 The hospital's address.
- 3 The hospital's CHAMPUS provider number.
- 4 The hospital's Medicare provider number.
- 5 The period covered--this must correspond to the hospital's Medicare cost-reporting period.
- 6 Total inpatient days provided to all patients in units subject to DRG-based payment.
- 7 Total allowed CHAMPUS inpatient days provided in units subject to DRG-based payment.
- 8 Total allowable capital costs.
- 9 Total allowable direct medical education costs.
- 10 Total full-time equivalents for:
 - a Residents.
 - b Interns

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11 Total inpatient beds as of the end of the cost-reporting period. If this has changed during the reporting period, an explanation of the change must be provided.

12 Title of official signing the report.

13 Reporting date.

14 The report shall contain a certification statement that any changes to the items in subparagraphs 6, 7, 8, 9, or 10, which are a result of an audit of the hospital's Medicare cost-report, shall be reported to CHAMPUS within thirty (30) days of the date the hospital is notified of the change.

2. CHAMPUS mental health per diem payment system. The CHAMPUS mental health per diem payment system shall be used to reimburse for inpatient mental health hospital care in specialty psychiatric hospitals and units. Payment is made on the basis of prospectively determined rates and paid on a per diem basis. The system uses two sets of per diems. One set of per diems applies to hospitals and units that have a relatively higher number of CHAMPUS discharges. For these hospitals and units, the system uses hospital-specific per diem rates. The other set of per diems applies to hospitals and units with a relatively lower number of CHAMPUS discharges. For these hospitals and units, the system uses regional per diems, and further provides for adjustments for area wage differences and indirect medical education costs and additional pass-through payments for direct medical education costs.

a. Applicability of the mental health per diem payment system.

(1) Hospitals and units covered. The CHAMPUS mental health per diem payment system applies to services covered (see subparagraph A.2.a.(2) below) that are provided in Medicare prospective payment system (PPS) exempt psychiatric specialty hospitals and all Medicare PPS exempt psychiatric specialty units of other hospitals. In addition, any psychiatric hospital that does not participate in Medicare, or any other hospital that has a psychiatric specialty unit that has not been so designated for exemption from the Medicare prospective payment system because the hospital does not participate in Medicare, may be designated as a psychiatric hospital or psychiatric specialty unit for purposes of the CHAMPUS mental health per diem payment system upon demonstrating that it meets the same criteria (as determined by the Director, OCHAMPUS) as required for the Medicare exemption. The CHAMPUS mental health per diem payment system does not apply to mental health services provided in other hospitals.

(2) Services covered. Unless specifically exempted, all covered hospitals' and units' inpatient claims which are classified into a mental health DRG (DRG categories 425-432, but not DRG 424) or an alcohol/drug abuse DRG (DRG categories 433-437) shall be subject to the mental health per diem payment system.

b. Hospital-specific per diems for higher volume hospitals and units. This paragraph describes the per diem payment amounts for hospitals and units with a higher volume of CHAMPUS discharges.

(1) Per diem amount. A hospital-specific per diem amount shall be calculated for each hospital and unit with a higher volume of CHAMPUS discharges. The base period per diem amount shall be equal to the hospital's average daily charge in the base period. The base period amount, however, may not exceed the cap described in subparagraph A.2.b.(2), below. The base period amount shall be updated in accord with paragraph A.2.d. of this chapter.

(2) Cap. The base period per diem amount may not exceed the eightieth percentile of the average daily charge weighted for all discharges throughout the United States from all higher volume hospitals.

(3) Review of per diem amount. Any hospital or unit which believes OCHAMPUS calculated a hospital-specific per diem which differs by more than \$5.00 from that calculated by the hospital or unit may apply to the Director, OCHAMPUS, or a designee, for a recalculation. The burden of proof shall be on the hospital.

c. Regional per diems for lower volume hospitals and units. This paragraph describes the per diem amounts for hospitals and units with a lower volume of CHAMPUS discharges.

(1) Per diem amounts. Hospitals and units with a lower volume of CHAMPUS patients shall be paid on the basis of a regional per diem amount, adjusted for area wages and indirect medical education. Base period regional per diems shall be calculated based upon all CHAMPUS lower volume hospitals' claims paid during the base period. Each regional per diem amount shall be the quotient of all covered charges divided by all covered days of care, reported on all CHAMPUS claims from lower volume hospitals in the region paid during the base period, after having standardized for indirect medical education costs and area wage indexes and subtracted direct medical education costs. Regional per diem amounts are adjusted in accordance with subparagraph A.2.c.(3), below. Additional pass-through payments to lower volume hospitals are made in accordance with subparagraph A.2.c.(4), below. The regions shall be the same as the federal census regions.

(2) Review of per diem amount. Any hospital that believes the regional per diem amount applicable to that hospital has been erroneously calculated by OCHAMPUS by more than \$5.00 may submit to the Director, OCHAMPUS, or a designee, evidence supporting a different regional per diem. The burden of proof shall be on the hospital.

(3) Adjustments to regional per diems. Two adjustments shall be made to the regional per diem rates.

(a) Area wage index. The same area wage indexes used for the CHAMPUS DRG-based payment system (see subparagraph A.1.c.(5)(b) of this chapter) shall be applied to the wage portion of the applicable regional per diem rate for each day of the admission. The wage portion shall be the same as that used for the CHAMPUS DRG-based payment system.

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(b) Indirect medical education. The indirect medical education adjustment factors shall be calculated for teaching hospitals in the same manner as is used in the CHAMPUS DRG-based payment system (see subparagraph A.1.c.(5)(c) of this chapter) and applied to the applicable regional per diem rate for each day of the admission.

(4) Annual cost pass-through for direct medical education. In addition to payments made to lower volume hospitals under paragraph A.2.c., CHAMPUS shall annually reimburse hospitals for actual direct medical education costs associated with services to CHAMPUS beneficiaries. This reimbursement shall be done pursuant to the same procedures as are applicable to the CHAMPUS DRG-based payment system (see subparagraph A.1.c.(7) of this chapter).

d. Base period and update factors.

(1) Base period. The base period for calculating the hospital-specific and regional per diems, as described in paragraphs A.2.b. and c. above, is federal fiscal year 1988. Base period calculations shall be based on actual claims paid during the period July 1, 1987 through May 31, 1988, trended forward to represent the 12-month period ending September 30, 1988 on the basis of the Medicare inpatient hospital market basket rate.

(2) Alternative hospital-specific data base. Upon application of a higher volume hospital or unit to the Director, OCHAMPUS, or a designee, the hospital or unit may have its hospital-specific base period calculations based on claims with a date of discharge (rather than date of payment) between July 1, 1987 through May 31, 1988 if it has generally experienced unusual delays in claims payments and if the use of such an alternative data base would result in a difference in the per diem amount of at least \$5.00. For this purpose, the unusual delays means that the hospital's or unit's average time period between date of discharge and date of payment is more than two standard deviations longer than the national average.

(3) Update factors. The hospital-specific per diems and the regional per diems calculated for the base period pursuant to paragraphs A.2.b. and c. of this chapter shall be in effect for federal fiscal year 1989; there will be no additional update for fiscal year 1989. For subsequent federal fiscal years, each per diem shall be updated by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system. Hospitals and units with hospital-specific rates will be notified of their respective rates prior to the beginning of each federal fiscal year. New hospitals shall be notified at such time as the hospital rate is determined. The actual amounts of each regional per diem that will apply in any federal fiscal year shall be published in the Federal Register prior to the start of that fiscal year.

e. Higher volume hospitals. This paragraph describes the classification of and other provisions pertinent to hospitals with a higher volume of CHAMPUS patients.

(1) In general. Any hospital or unit that had an annual rate of 25 or more CHAMPUS discharges of CHAMPUS patients during the period July 1, 1987 through May 31, 1988 shall be considered a higher volume hospital during federal fiscal year 1989 and all subsequent fiscal years. All other hospitals and units covered by the CHAMPUS mental health per diem payment system shall be considered lower volume hospitals.

(2) Hospitals that subsequently become higher volume hospitals. In any federal fiscal year in which a hospital, including a new hospital (see subparagraph A.2.e.(3) below), not previously classified as a higher volume hospital has 25 or more CHAMPUS discharges, that hospital shall be considered to be a higher volume hospital during the next federal fiscal year and all subsequent fiscal years. The hospital specific per diem amount shall be calculated in accordance with the provisions of paragraph A.2.b. of this chapter, except that the base period average daily charge shall be deemed to be the hospital's average daily charge in the year in which the hospital had 25 or more discharges, adjusted by the percentage change in average daily charges for all higher volume hospitals and units between the year in which the hospital had 25 or more CHAMPUS discharges and the base period. The base period amount, however, may not exceed the cap described in subparagraph A.2.b.(2) of this chapter.

(3) Special retrospective payment provision for new hospitals. For purposes of this subparagraph, a new hospital is a hospital that qualifies for the Medicare exemption from the rate of increase ceiling applicable to new hospitals which are PPS-exempt psychiatric hospitals. Any new hospital that becomes a higher volume hospital, in addition to qualifying prospectively as a higher volume hospital for purposes of subparagraph A.2.e.(2) above, may additionally, upon application to the Director, OCHAMPUS, receive a retrospective adjustment. The retrospective adjustment shall be calculated so that the hospital receives the same government share payments it would have received had it been designated a higher volume hospital for the federal fiscal year in which it first had 25 or more CHAMPUS discharges and the preceding fiscal year (if it had any CHAMPUS patients during the preceding fiscal year). Such new hospitals must agree not to bill CHAMPUS beneficiaries for any additional costs beyond that determined initially.

(4) Review of classification. Any hospital or unit which OCHAMPUS erroneously fails to classify as a higher volume hospital may apply to the Director, OCHAMPUS, or a designee, for such a classification. The hospital shall have the burden of proof.

f. Payment for hospital based professional services. Lower volume hospitals and units may not bill separately for hospital based professional mental health services; payment for those services is included in the per diems. Higher volume hospitals and units, whether they billed CHAMPUS separately for hospital based professional mental health services or included those services in the hospital's billing to CHAMPUS, shall continue the practice in effect during the period July 1, 1987 to May 31, 1988 (or other data base period used for calculating the hospital's or unit's per diem), except that any such hospital or unit may change its prior practice (and obtain an appropriate revision in its per diem) by providing to OCHAMPUS

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notice in accordance with procedures established by the Director, OCHAMPUS, or a designee.

g. Leave days. CHAMPUS shall not pay for days where the patient is absent on leave from the specialty psychiatric hospital or unit. The hospital must identify these days when claiming reimbursement. CHAMPUS shall not count a patient's leave of absence as a discharge in determining whether a facility should be classified as a higher volume hospital pursuant to paragraph A.2.e. of this chapter.

h. Exemptions from the CHAMPUS mental health per diem payment system. The following providers and procedures are exempt from the CHAMPUS mental health per diem payment system.

(1) Non-specialty providers. Providers of inpatient care which are not either psychiatric hospitals or psychiatric specialty units as described in subparagraph A.2.a.(1) of this chapter are exempt from the CHAMPUS mental health per diem payment system. Such providers should refer to subsection A.1. of this chapter for provisions pertinent to the CHAMPUS DRG-based payment system.

(2) DRG 424. Admissions for operating room procedures involving a principal diagnosis of mental illness (services which group into DRG 424) are exempt from the per diem payment system. They will be reimbursed pursuant to the provisions of subsection A.3. of this chapter.

(3) Non-mental health services. Admissions for non-mental health procedures in specialty psychiatric hospitals and units are exempt from the per diem payment system. They will be reimbursed pursuant to the provisions of subsection A.3. of this chapter.

(4) Sole community hospitals. Any hospital which has qualified for special treatment under the Medicare prospective payment system as a sole community hospital and has not given up that classification is exempt.

(5) Hospitals outside the U.S. A hospital is exempt if it is not located in one of the 50 states, the District of Columbia or Puerto Rico.

3. Billed charges and set rates. The allowable costs for authorized care in all hospitals not subject to the CHAMPUS DRG-based payment system or the CHAMPUS mental health per diem payment system shall be determined on the basis of billed charges or set rates. Under this procedure the allowable costs may not exceed the lower of:

a. The actual charge for such service made to the general public;
or

b. The allowed charge applicable to the policyholders or subscribers of the CHAMPUS fiscal intermediary for comparable services under comparable circumstances, when extended to CHAMPUS beneficiaries by consent or agreement; or

c. The allowed charge applicable to the citizens of the community

or state as established by local or state regulatory authority, excluding title XIX of the Social Security Act or other welfare program, when extended to CHAMPUS beneficiaries by consent or agreement.

4. CHAMPUS discount rates. The CHAMPUS-determined allowable cost for authorized care in any hospital may be based on discount rates established under section I. of this chapter.

B. SKILLED NURSING FACILITIES (SNFs)

The CHAMPUS-determined allowable cost for reimbursement of a SNF shall be determined on the same basis as for hospitals which are not subject to the CHAMPUS DRG-based payment system.

C. REIMBURSEMENT FOR OTHER THAN HOSPITALS AND SNFs

The Director, OCHAMPUS, or a designee, shall establish such other methods of determining allowable cost or charge reimbursement for those institutions, other than hospitals and SNFs, as may be required.

D. REIMBURSEMENT OF FREESTANDING AMBULATORY SURGICAL CENTERS

Authorized care furnished by freestanding ambulatory surgical centers shall be reimbursed on the basis of the CHAMPUS-determined reasonable cost.

E. REIMBURSEMENT OF BIRTHING CENTERS

1. Reimbursement for maternity care and childbirth services furnished by an authorized birthing center shall be limited to the lower of the CHAMPUS established all-inclusive rate or the center's most-favored all-inclusive rate.

2. The all-inclusive rate shall include the following to the extent that they are usually associated with a normal pregnancy and childbirth: laboratory studies, prenatal management, labor management, delivery, post-partum management, newborn care, birth assistant, certified nurse-midwife professional services, physician professional services, and the use of the facility.

3. The CHAMPUS established all-inclusive rate is equal to the sum of the CHAMPUS area prevailing professional charge for total obstetrical care for a normal pregnancy and delivery and the sum of the average CHAMPUS allowable institutional charges for supplies, laboratory, and delivery room for a hospital inpatient normal delivery. The CHAMPUS established all-inclusive rate areas will coincide with those established for prevailing professional charges and will be updated concurrently with the CHAMPUS area prevailing professional charge database.

4. Extraordinary maternity care services, when otherwise authorized, may be reimbursed at the lesser of the billed charge or the CHAMPUS allowable charge.

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5. Reimbursement for an incomplete course of care will be limited to claims for professional services and tests where the beneficiary has been screened but rejected for admission into the birthing center program, or where the woman has been admitted but is discharged from the birthing center program prior to delivery, adjudicated as individual professional services and items.

6. The beneficiary's share of the total reimbursement to a birthing center is limited to the cost-share amount plus the amount billed for non-covered services and supplies.

F. REIMBURSEMENT OF RESIDENTIAL TREATMENT CENTERS

The CHAMPUS rate is the per diem rate that CHAMPUS will authorize for all mental health services rendered to a patient and the patient's family as part of the total treatment plan submitted by a CHAMPUS-approved RTC, and approved by the Director, OCHAMPUS, or designee.

1. The all-inclusive per diem rate for RTCs operating or participating in CHAMPUS during the base period of July 1, 1987, through June 30, 1988, will be the lowest of the following conditions:

a. The CHAMPUS rate paid to the RTC for all-inclusive services as of June 30, 1988, adjusted by the Consumer Price Index - Urban (CPI-U) for medical care as determined applicable by the Director, OCHAMPUS, or designee; or

b. The per diem rate accepted by the RTC from any other agency or organization (public or private) that is high enough to cover one-third of the total patient days during the 12-month period ending June 30, 1988, adjusted by the CPI-U; or

NOTE: The per diem rate accepted by the RTC from any other agency or organization includes the rates accepted from entities such as Government contractors in CHAMPUS demonstration projects.

c. An OCHAMPUS determined capped per diem amount not to exceed the 80th percentile of all established CHAMPUS RTC rates nationally, weighted by total CHAMPUS days provided at each rate during the base period discussed in F.1. above.

2. The all-inclusive per diem rates for RTCs which began operation after June 30, 1988, or began operation before July 1, 1988, but had less than 6 months of operation by June 30, 1988, will be calculated based on the lower of the per diem rate accepted by the RTC that is high enough to cover one-third of the total patient days during its first 6 to 12 consecutive months of operation, or the OCHAMPUS determined capped amount. Rates for RTCs beginning operation prior to July 1, 1988, will be adjusted by an appropriate CPI-U inflation factor for the period ending June 30, 1988. A period of less than 12 months will be used only when the RTC has been in operation for less than 12 months. Once a full 12 months is available, the rate will be recalculated.

3. The first three days of each approved therapeutic absence will be allowed at 100 percent of the CHAMPUS determined all-inclusive per diem rate. Beginning with day four, reimbursement will be at 75 percent of that rate.

4. All educational costs, whether they include routine education or special education costs, are excluded from reimbursement except when appropriate education is not available from, or not payable by, a cognizant public entity.

a. The RTC shall exclude educational costs from its daily costs.

b. The RTC's accounting system must be adequate to assure CHAMPUS is not billed for educational costs.

c. The RTC may request payment of educational costs on an individual case basis from the Director, OCHAMPUS, or designee, when appropriate education is not available from, or not payable by, a cognizant public entity. To qualify for reimbursement of educational costs in individual cases, the RTC shall comply with the application procedures established by the Director, OCHAMPUS, or designee, including, but not limited to, the following:

(1) As part of its admission procedures, the RTC must counsel and assist the beneficiary and the beneficiary's family in the necessary procedures for assuring their rights to a free and appropriate public education.

(2) The RTC must document any reasons why an individual beneficiary cannot attend public educational facilities and, in such a case, why alternative educational arrangements have not been provided by the cognizant public entity.

(3) If reimbursement of educational costs is approved for an individual beneficiary by the Director, OCHAMPUS, or designee, such educational costs shall be shown separately from the RTC's daily costs on the CHAMPUS claim. The amount paid shall not exceed the RTC's most-favorable rate to any other patient, agency, or organization for special or general educational services whichever is appropriate.

(4) If the RTC fails to request CHAMPUS approval of the educational costs on an individual case, the RTC agrees not to bill the beneficiary or the beneficiary's family for any amounts disallowed by CHAMPUS. Requests for payment of educational costs must be referred to the Director, OCHAMPUS, or designee for review and a determination of the applicability of CHAMPUS benefits.

5. Any future adjustments to the RTC rates will be limited to annual changes in the CPI-U for medical care. at the discretion of the Director, OCHAMPUS or designee.

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**G. REIMBURSEMENT OF INDIVIDUAL HEALTH-CARE PROFESSIONALS AND OTHER
NON-INSTITUTIONAL HEALTH-CARE PROVIDERS**

The CHAMPUS-determined reasonable charge (the amount allowed by CHAMPUS) for the service of an individual health-care professional or other non-institutional health-care provider (even if employed by or under contract to an institutional provider) shall be determined by one of the following methodologies, that is, whichever is in effect in the specific geographic location at the time covered services and supplies are provided to a CHAMPUS beneficiary.

1. Allowable charge method. The allowable charge method is the preferred and primary method for reimbursement of individual health-care professionals and other non-institutional health-care providers.

a. The allowable charge for authorized care shall be the lowest of the amounts identified in subparagraphs (1), (2), and (3) below.

(1) The billed charge for the service.

(2) The prevailing charge level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services in the same locality during the base period.

NOTE: Prevailing charges shall continue to be calculated in accordance with any limitations set forth in the DoD Appropriation Acts, as implemented in instructions issued by the Director, OCHAMPUS.

(a) The 80th percentile of charges shall be determined on the basis of statistical data and methodology acceptable to the Director, OCHAMPUS, or a designee.

(b) The base period shall be a period of 12 calendar months and shall be adjusted at least once a year, unless the Director, OCHAMPUS, determines that a different period for adjustment is appropriate and publishes a notice to that effect in the Federal Register. Prior to publishing the final notice, a notice of intent shall have been published, which allowed a 30-day period for public comment on the proposed action.

(3) For charges from physicians and other individual professional providers, the fiscal year 1988 prevailing charges adjusted by the Medicare Economic Index (MEI), as the MEI is applied to Medicare prevailing charge levels.

(a) In any year in which the Medicare program applies a different MEI to primary care services, CHAMPUS will include maternity care and delivery services and well baby care services as primary care for the purposes of applying the MEI.

(b) The Director, OCHAMPUS, shall issue procedural instructions to apply the MEI under CHAMPUS.

b. A charge that exceeds the prevailing charge can be determined to be allowable only when unusual circumstances or medical complications justify the higher charge. The allowable charge may not exceed the billed charge under any circumstances.

c. The allowable charge for physician assistant services other than assistant-at-surgery may not exceed 85 percent of the allowable charge for a comparable service rendered by a physician performing the service in a similar location. For cases in which the physician assistant and the physician perform component services of a procedure other than assistant-at-surgery (e.g., home, office or hospital visit), the combined allowable charge for the procedure may not exceed the allowable charge for the procedure rendered by a physician alone. The allowable charge for physician assistant services performed as an assistant-at-surgery may not exceed 65 percent of the allowable charge for a physician serving as an assistant surgeon when authorized as CHAMPUS benefits in accordance with the provisions of Chapter 4 C.3.c. of this Part. Physician assistant services must be billed through the employing physician who must be an authorized CHAMPUS provider.

2. All-inclusive rate. Claims from individual health-care professional providers for services rendered to CHAMPUS beneficiaries residing in an RTC that is either being reimbursed on an all-inclusive per diem rate, or is billing an all-inclusive per diem rate, shall be denied; with the exception of independent health-care professionals providing geographically distant family therapy to a family member residing a minimum of 250 miles from the RTC or covered medical services related to a nonmental health condition rendered outside the RTC. Reimbursement for individual professional services is included in the rate paid the institutional provider.

3. Alternative method. The Director, OCHAMPUS, or a designee, may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to ensure a high level of acceptance of the CHAMPUS-determined charge by the individual health-care professionals or other noninstitutional health-care providers furnishing services and supplies to CHAMPUS beneficiaries. Alternative methods may not result in reimbursement greater than the allowable charge method above.

H. REIMBURSEMENT UNDER THE MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM

The Military-Civilian Health Services Partnership Program, as authorized by Section 1096, Chapter 55, Title 10, provides for the sharing of staff, equipment, and resources between the civilian and military health care system in order to achieve more effective, efficient, or economical health care for authorized beneficiaries. Military treatment facility commanders, based upon the authority provided by their respective Surgeons General of the military departments, are responsible for entering into individual partnership agreements only when they have determined specifically that use of the Partnership Program is more economical overall to the Government than referring the need for health care services to the civilian community under the normal operation of the CHAMPUS Program. (See Section P. of Chapter 1, for general requirements of the Partnership Program.)

1. Reimbursement of institutional health care providers. Reimbursement of institutional health care providers under the Partnership Program shall be on the same basis as non-Partnership providers.

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2. Reimbursement of individual health-care professionals and other non-institutional health care providers. Reimbursement of individual health care professional and other non-institutional health care providers shall be on the same basis as non-Partnership providers as detailed in Section G. of this chapter.

I. ACCOMMODATION OF DISCOUNTS UNDER PROVIDER REIMBURSEMENT METHODS

1. General rule. The Director, OCHAMPUS (or designee) has authority to reimburse a provider at an amount below the amount usually paid pursuant to this chapter when, under a program approved by the Director, the provider has agreed to the lower amount.

2. Special applications. The following are examples of applications of the general rule; they are not all inclusive.

a. In the case of individual health care professionals and other noninstitutional providers, if the discounted fee is below the provider's normal billed charge and the prevailing charge level (see section G. of this chapter), the discounted fee shall be the provider's actual billed charge and the CHAMPUS allowable charge.

b. In the case of institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under subsection A.1. of this chapter or per-diem amount under subsection A.2. of this chapter), if the discount rate is lower than the pre-set rate, the discounted rate shall be the CHAMPUS-determined allowable cost. This is an exception to the usual rule that the pre-set rate is paid regardless of the institutional provider's billed charges or other factors.

3. Procedures.

a. This section only applies when both the provider and the Director have agreed to the discounted payment rate. The Director's agreement may be in the context of approval of a program that allows for such discounts.

b. The Director of OCHAMPUS may establish uniform terms, conditions and limitations for this payment method in order to avoid administrative complexity.

J. OUTSIDE THE UNITED STATES

The Director, OCHAMPUS, or a designee, shall determine the appropriate reimbursement method or methods to be used in the extension of CHAMPUS benefits for otherwise covered medical services or supplies provided by hospitals or other institutional providers, physicians or other individual professional providers, or other providers outside the United States.

K. IMPLEMENTING INSTRUCTIONS

The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this chapter.

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CHAPTER 15

PEER REVIEW ORGANIZATION PROGRAM

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CHAPTER 15
PEER REVIEW ORGANIZATION PROGRAM

A. GENERAL

This chapter establishes rules and procedures applicable to the CHAMPUS Peer Review Organization (PRO) program for utilization and quality review of services, especially services provided in hospitals for which the hospital care is covered by the CHAMPUS DRG-based payment system. In implementing the provisions of this chapter, OCHAMPUS will, in accordance with section 9100 of Public Law 101-165, be guided by the general policy of following Medicare PRO program requirements and procedures, with appropriate adaptations.

B. OBJECTIVES OF REVIEW SYSTEM

There are four required functions:

1. A review of the completeness, adequacy and quality of care provided;
2. A review of the reasonableness, necessity and appropriateness of hospital admissions under CHAMPUS DRG reimbursement;
3. A validation of diagnoses and procedural information that determines CHAMPUS reimbursement; and
4. A review of the necessity and appropriateness of care for which payment is sought on an outlier basis.

C. HOSPITAL COOPERATION

All hospitals which participate in CHAMPUS and submit CHAMPUS claims are required to provide all information necessary for CHAMPUS to properly process the claims. In order for CHAMPUS to be assured that services for which claims are submitted meet quality of care standards, hospitals are required to provide the Peer Review Organization (PRO) responsible for quality review with all the information, within timeframes to be established by OCHAMPUS, necessary to perform the review functions required by this chapter. Additionally, all participating hospitals shall provide CHAMPUS beneficiaries, upon admission, with information about the admission and quality review system including their appeal rights. A hospital which does not cooperate in this activity shall be subject to termination as a CHAMPUS-authorized provider.

1. Documentation that the beneficiary has received the required information about the CHAMPUS PRO program must be maintained in the same manner as is the notice required for the Medicare program by 42 CFR 466.78(b).
2. The physician attestation and physician acknowledgement required for Medicare under 42 CFR 412.40 and 412.46 are also required for CHAMPUS as a condition for payment and may be satisfied by the same statements as required for Medicare, with substitution or addition of "CHAMPUS" when the word "Medicare" is used.

3. Participating hospitals must execute a memorandum of understanding with the PRO providing appropriate procedures for implementation of the PRO program.

4. Participating hospitals may not charge a CHAMPUS beneficiary for inpatient hospital services excluded on the basis of Chapter 4, section G.1. (not medically necessary), section G.3. (inappropriate level), or section G.7. (custodial care) unless all of the conditions established by 42 CFR 412.42(c) with respect to Medicare beneficiaries have been met with respect to the CHAMPUS beneficiary. In such cases in which the patient requests a PRO review while the patient is still an inpatient in the hospital, the hospital shall provide to the PRO the records required for the review by the close of business of the day the patient requests review, if such request was made before noon. If the hospital fails to provide the records by the close of business, that day and any subsequent working day during which the hospital continues to fail to provide the records shall not be counted for purposes of the two-day period of 42 CFR 412.42(c)(3)(ii).

5. With respect to cases subject to preadmission review, the provisions of 42 C.F.R. 466.78(b)(5)-(b)(7) shall apply to CHAMPUS cases as those provisions apply to Medicare cases.

D. AREAS OF REVIEW

1. Admissions. The following areas shall be subject to review to determine whether inpatient care was medically appropriate and necessary, was delivered in the most appropriate setting and met acceptable standards of quality. This review may include preadmission or prepayment review when appropriate.

a. Transfers of CHAMPUS beneficiaries from a hospital or hospital unit subject to the CHAMPUS DRG-based payment system to another hospital or hospital unit.

b. CHAMPUS admissions to a hospital or hospital unit subject to the CHAMPUS DRG-based payment system which occur within a certain period (specified by OCHAMPUS) of discharge from a hospital or hospital unit subject to the CHAMPUS DRG-based payment system.

c. A random sample of other CHAMPUS admissions for each hospital subject to the CHAMPUS DRG-based payment system.

d. CHAMPUS admissions in any DRGs which have been specifically identified by OCHAMPUS for review or which are under review for any other reason.

2. DRG validation. The review organization responsible for quality of care reviews shall be responsible for ensuring that the diagnostic and procedural information reported by hospitals on CHAMPUS claims which is used by the fiscal intermediary to assign claims to DRGs is correct and matches the information contained in the medical records. In order to accomplish this, the following review activities shall be done.

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- a. Perform DRG validation reviews of each case under review.
- b. Review of claim adjustments submitted by hospitals which result in the assignment of a higher weighted DRG.
- c. Review for physician certification as to the major diagnoses and procedures and the physician's acknowledgment of annual receipt of the penalty statement as contained in the Medicare regulations at 42 CFR 412.40 and 412.46.
- d. Review of a sample of claims for each hospital reimbursed under the CHAMPUS DRG-based payment system. Sample size shall be determined based upon the volume of claims submitted.

3. Outlier review. Claims which qualify for additional payment as a long-stay outlier or as a cost-outlier shall be subject to review to ensure that the additional days or costs were medically necessary and appropriate and met all other requirements for CHAMPUS coverage. In addition, claims which qualify as short-stay outliers shall be reviewed to ensure that the admission was medically necessary and appropriate and that the discharge was not premature.

4. Procedure review. Claims for procedures identified by OCHAMPUS as subject to a pattern of abuse shall be the subject of intensified quality assurance review.

5. Other review. Any other cases or types of cases identified by OCHAMPUS shall be subject to focused review.

E. ACTIONS AS A RESULT OF REVIEW

1. Findings related to individual claims. If it is determined, based upon information obtained during reviews, that a hospital has misrepresented admission, discharge, or billing information, or is found to have quality of care defects, or has taken an action that results in the unnecessary admissions of an individual entitled to benefits, unnecessary multiple admission of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, the PRO, in conjunction with the fiscal intermediary, shall, as appropriate:

- a. Deny payment for or recoup (in whole or in part) any amount claimed or paid for the inpatient hospital and professional services related to such determination.

- b. Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

- c. Advise the provider and beneficiary of appeal rights, as required by Chapter 10 of this Regulation.

- d. Notify OCHAMPUS of all such actions.

2. Findings related to a pattern of inappropriate practices. In all cases where a pattern of inappropriate admissions and billing practices that have the effect of circumventing the CHAMPUS DRG-based payment system is identified, OCHAMPUS shall be notified of the hospital and practice involved.

3. Revision of coding relating to DRG validation. The following provisions apply in connection with the DRG validation process set forth in subsection D.2. of this chapter.

a. If the diagnostic and procedural information attested to by the attending physician is found to be inconsistent with the hospital's coding or DRG assignment, the hospital's coding on the CHAMPUS claim will be appropriately changed and payments recalculated on the basis of the appropriate DRG assignment.

b. If the information attested to by the physician as stipulated under subsection E.2. of this chapter is found not to be correct, the PRO will change the coding and assign the appropriate DRG on the basis of the changed coding.

F. PROCEDURES REGARDING CERTAIN SERVICES, INCLUDING SERVICES NOT COVERED BY THE DRG-BASED PAYMENT SYSTEM

Sections B. through E. of this chapter are directed to the context of services covered by the CHAMPUS DRG-based payment system. The Director, OCHAMPUS, may activate PRO program review (using the same PROs or other similar organizations) of services not covered by the DRG-based payment system. For any such review activity designated by the Director, OCHAMPUS, the provisions of sections G. through M. of this chapter shall apply. In addition, the Director, OCHAMPUS, may establish procedures, appropriate to the types of services to be reviewed, substantively comparable to those applicable to services covered by the DRG-based payment system pertaining to obligations of providers to cooperate in PRO program review activities, authority to require precertification of services proposed to be required and authorities to require appropriate corrective actions. The Director, OCHAMPUS, may also establish such procedures for review of services which, although covered by the DRG-based payment system, are also affected by some other special circumstances concerning payment method, nature of care or other potential quality or utilization issue.

G. PROCEDURES REGARDING INITIAL DETERMINATIONS

The CHAMPUS PROs shall establish and follow procedures for initial determinations that are substantively the same or comparable to the procedures applicable to Medicare under 42 CFR 466.83 to 466.104. In addition, these procedures shall provide that a PRO's determination that an admission is medically necessary is not a guarantee of payment by CHAMPUS; normal CHAMPUS benefit and procedural coverage requirements must also be applied.

H. PROCEDURES REGARDING RECONSIDERATIONS

The CHAMPUS PROs shall establish and follow procedures for reconsiderations that are substantively the same or comparable to the

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procedures applicable to reconsiderations under Medicare pursuant to 42 CFR 473.15 to 473.34, except that the time limit for requesting reconsideration (see 42 CFR 473.20(a)(1)) shall be 90 days. A PRO reconsidered determination is final and binding upon all parties to the reconsideration except to the extent of any further appeal pursuant to section I. of this chapter.

I. APPEALS AND HEARINGS

1. Beneficiaries may appeal a PRO reconsideration determination to OCHAMPUS and obtain a hearing on such appeal to the extent allowed and under the procedures set forth in Chapter 10, section D.

2. Except as provided in subsection I.3., a PRO reconsidered determination may not be further appealed by a provider.

3. A provider may appeal a PRO reconsideration determination to OCHAMPUS and obtain a hearing on such appeal to the extent allowed under the procedures set forth in Chapter 10, section D. if it is a determination pursuant to Chapter 4, section H. that the provider knew or could reasonably have been expected to know that the services were excludable.

4. For purposes of the hearing process, a PRO reconsidered determination shall be considered as the procedural equivalent of a formal review determination under Chapter 10.

5. The provisions of Chapter 10, section E. concerning final action shall apply to hearings cases.

J. ACQUISITION, PROTECTION AND DISCLOSURE OF PEER REVIEW INFORMATION

The provisions of 42 CFR Part 476, except section 476.108, shall be applicable to the CHAMPUS PRO program as they are to the Medicare PRO program.

K. LIMITED IMMUNITY FROM LIABILITY FOR PARTICIPANTS IN PRO PROGRAM

The provisions of section 1157 of the Social Security Act (42 U.S.C. 1320c-6) are applicable to the CHAMPUS PRO program in the same manner as they apply to the Medicare PRO program. Section 1102(g) of title 10, United States Code also applies to the CHAMPUS PRO program.

L. ADDITIONAL PROVISION REGARDING CONFIDENTIALITY OF RECORDS

1. General rule. The provisions of 10 U.S.C. 1102 regarding the confidentiality of medical quality assurance records shall apply to the activities of the CHAMPUS PRO program as they do to the activities of the external civilian PRO program that reviews medical care provided in military hospitals.

2. Specific applications.

a. Records concerning PRO deliberations are generally nondisclosable quality assurance records under 10 U.S.C. 1102.

b. Initial denial determinations by PROs pursuant to section G. of this chapter (concerning medical necessity determinations, DRG validation actions, etc.) and subsequent decisions regarding those determinations are not nondisclosable quality assurance records under 10 U.S.C. 1102.

c. Information the subject of mandatory PRO disclosure under 42 CFR Part 476 is not a nondisclosable quality assurance record under 10 U.S.C. 1102.

M. OBLIGATIONS, SANCTIONS AND PROCEDURES

1. The provisions of 42 CFR 1004.1 - 1004.80 shall apply to the CHAMPUS PRO program as they do the Medicare PRO program, except that the functions specified in those sections for the Office of Inspector General of the Department of Health and Human Services shall be the responsibility of OCHAMPUS.

2. The provisions of 42 U.S.C. section 1395ww(f)(2) concerning circumvention by any hospital of the applicable payment methods for inpatient services shall apply to CHAMPUS payment methods as they do to Medicare payment methods.

3. The Director, or a designee, of CHAMPUS shall determine whether to impose a sanction pursuant to subsections M.1. and M.2. of this chapter. Providers may appeal adverse sanctions decisions under the procedures set forth in Chapter 10, section D.

CHAPTER 16

SUPPLEMENTAL HEALTH CARE PROGRAM FOR ACTIVE DUTY MEMBERS

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Jul 12, 91

CHAPTER 16
SUPPLEMENTAL HEALTH CARE PROGRAM FOR ACTIVE DUTY MEMBERS

A. Purpose and applicability.

1. The purpose of this chapter is to implement, with respect to certain hospital services provided under the supplemental health care program for active duty members of the uniformed services, the provision of 10 U.S.C. 1074(c). This statute authorizes DoD to establish for the supplemental care program the same payment rules, subject to appropriate modifications, as apply under CHAMPUS.

2. This chapter applies to the program, known as the supplemental care program, which provides for the payment by the uniformed services to private sector health care providers for health care services provided to active duty members of the uniformed services. Although not part of CHAMPUS, the supplemental care program is similar to CHAMPUS in that it is a program for the uniformed services to purchase civilian health care services for active duty members. For this reason, the Director, OCHAMPUS, assists the uniformed services in the administration of the supplemental care program.

3. This chapter applies to inpatient hospital services covered by the CHAMPUS DRG-based payment system.

B. Obligation of hospitals concerning payment for supplemental health care for active duty members. For a hospital covered by the CHAMPUS DRG-based payment system to maintain its status as an authorized provider for CHAMPUS pursuant to Chapter 6, that hospital must also be a participating provider for purposes of the supplemental care program. As a participating provider, each hospital must accept the DRG-based payment system amount determined pursuant to this chapter as payment in full for the hospital services covered by the system. The failure of any hospital to comply with this obligation subjects that hospital to exclusion as a CHAMPUS-authorized provider.

C. General rule for payment and administration Subject to the special rules and procedures in Section D. of this chapter, and the waiver authority in Section E. of this chapter, as a general rule the provisions of subsection A.1. of Chapter 14 shall govern payment and administration of claims from hospitals covered by the CHAMPUS DRG-based payment system under the supplemental care program as they do claims under CHAMPUS. To the extent necessary to interpret or implement the provisions of subsection A.1. of Chapter 14, related provisions of DoD 6010.8-R shall also be applicable.

D. Special rules and procedures. As exceptions to the general rule in Section C. of this chapter, the special rules and procedures in this section shall govern payment and administration of claims from hospitals covered by the CHAMPUS DRG-based payment system under the supplemental care program. These special rules and procedures are subject to the waiver authority of Section E. of this chapter.

1. There is no patient cost sharing under the supplemental care program. All amounts due to be paid to the provider shall be paid by the program.

2. Preauthorization by the uniformed services of each hospital admission, except for an emergency inpatient admission (the definition in Chapter 2 shall apply), is required for the supplemental care program. It is the responsibility of the active duty member to obtain preauthorization for each admission. With respect to each emergency inpatient admission, after such time as the emergency condition is addressed, authorization for any proposed continued stay must be obtained within two working days of admission.

3. With respect to the filing of claims and similar administrative matters under the CHAMPUS DRG-based payment system for which DoD 6010.8-R refers to activities of the CHAMPUS fiscal intermediaries, for purposes of the supplemental care program, responsibilities for claims processing, payment and some other administrative matters will be assigned to the nearest military medical treatment facility or medical claims office.

4. The annual cost pass-throughs for capital and direct medical education costs that are available under the CHAMPUS DRG-based payment system are also available, upon request, under the supplemental care program. To obtain payment include the number of active duty bed days as a separate line item on the annual request to the CHAMPUS fiscal intermediaries. The fiscal intermediaries will process the requests on behalf of the supplemental care program. However, payment will be issued by the Department of Defense.

E. Waiver authority. With the exception of statutory requirements, any restrictions or limitation pursuant to the general rule in Section C. and special rules and procedures in Section D. may be waived by an authorized official of the uniformed service concerned based on a determination that such waiver is necessary to assure adequate availability of health care services to active duty members.

F. Authorities.

1. The Uniformed Services may establish additional procedures, consistent with this chapter, for the effective administration of the supplemental care program in their respective services.

2. The Assistant Secretary of Defense for Health Affairs is responsible for the overall policy direction of the supplemental care program and the administration of this chapter.

**DEPARTMENT OF DEFENSE
PUBLICATION SYSTEM
CHANGE TRANSMITTAL**

OFFICE OF THE SECRETARY OF DEFENSE
Assistant Secretary of Defense (Health Affairs)

CHANGE NO. 1
to July 1991 Reprint
DoD 6010.8-R
September 12, 1991

CIVILIAN HEALTH AND MEDICAL PROGRAM
OF THE UNIFORMED SERVICES (CHAMPUS)

The Principal Deputy Assistant Secretary of Defense (Health Affairs), has authorized the following page changes to DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," July 1991 (Reprint).

PAGE CHANGES

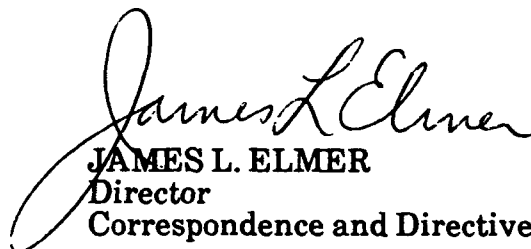
Remove: 4-42c through 4-46a, 7-1, and 7-2

Insert: Attached replacement pages

Changes appear on pages 4-42c through 4-45 and 7-1 and are indicated by marginal bars.

EFFECTIVE DATE

The above changes are effective immediately.


JAMES L. ELMER
Director
Correspondence and Directives

Attachments
8 pages

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, THIS TRANSMITTAL SHOULD BE FILED WITH THE BASIC DOCUMENT

2. Dependents of active duty members of the Uniformed Services.
CHAMPUS beneficiary or sponsor liability set forth for dependents of active duty members is as follows:

a. Annual fiscal year deductible for outpatient services and supplies.

(1) For care rendered all eligible beneficiaries prior to April 1, 1991, or when the active duty sponsor's pay grade is E-4 or below, regardless of the date of care:

(a) Individual Deductible: Each beneficiary is liable for the first fifty dollars (\$50.00) of the CHAMPUS-determined allowable amount on claims for care provided in the same fiscal year.

(b) Family Deductible: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed one hundred dollars (\$100.00).

(2) For care rendered on or after April 1, 1991, for all CHAMPUS beneficiaries except dependents of active duty sponsors of pay grades E-4 or below:

(a) Individual Deductible: Each beneficiary is liable for the first one hundred and fifty dollars (\$150.00) of the CHAMPUS-determined allowable amount on claims for care provided in the same fiscal year.

(b) Family Deductible: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed three hundred dollars (\$300.00).

(3) CHAMPUS-Approved Ambulatory Surgical Centers or Birthing Centers. No deductible shall be applied to allowable amounts for services or items rendered to active duty or authorized NATO dependents.

(4) Allowable Amount does not exceed Deductible Amount. If fiscal year allowable amounts for two or more beneficiary members of a family total less than \$100.00 (\$300.00 if 2.a.(2)(b) above applies), but none of the beneficiary members submit a claim for over \$50.00 (\$150.00 if 2.a.(2)(a) above applies), neither the family nor the individual deductible will have been met and no CHAMPUS benefits are payable.

(5) For any family the outpatient deductible amounts will be applied sequentially as the CHAMPUS claims are processed.

(6) If the fiscal year outpatient deductible under either F.2.a.(1) or F.2.a.(2) above has been met by a beneficiary or a family through the submission of a claim or claims to a CHAMPUS fiscal intermediary in another geographic location from the location where a current claim is being submitted, the beneficiary or sponsor must obtain a deductible certificate from the CHAMPUS fiscal intermediary where the applicable beneficiary or family fiscal year deductible was met. Such deductible certificate must be attached to the current claim being submitted for benefits. Failure to obtain a deductible certificate

under such circumstances will result in a second beneficiary or family fiscal year deductible being applied. However, this second deductible may be reimbursed once appropriate documentation, as described in this subparagraph F.2.a.(6), is supplied to the CHAMPUS fiscal intermediary applying the second deductible (refer to section A. of Chapter 7 of this Regulation).

(7) Notwithstanding the dates specified in paragraphs F.2.a.(1) and (2), in the case of the dependents of active duty members of rank E-5 or above with Persian Gulf conflict service, the deductible shall be the amount specified in paragraph (1) for care rendered prior to October 1, 1991, and the amount specific in paragraph (2) for care rendered after October 1, 1991. For purposes of the preceding sentence, a member with Persian Gulf conflict service is a member who is, or was entitled to special pay for hostile fire/imminent danger authorized by 37 U.S.C. 310, for services in the Persian Gulf area in connection with Operation Desert Shield or Operation Desert Storm.

b. Inpatient cost-sharing. Dependents of active duty members of the Uniformed Services or their sponsors are responsible for the payment of the first \$25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider (refer to Chapter 6 of this Regulation), or the amount the beneficiary or sponsor would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater.

NOTE: The Secretary of Defense (after consulting with the Secretary of Health and Human Services and the Secretary of Transportation) prescribes the fair charges for inpatient hospital care provided through Uniformed Services medical facilities. This determination is made each fiscal year.

(1) Inpatient cost-sharing payable with each separate inpatient admission. A separate cost-sharing amount (as described in this subsection F.2.) is payable for each inpatient admission to a hospital or other authorized institution, regardless of the purpose of the admission (such as medical or surgical), regardless of the number of times the beneficiary is admitted, and regardless of whether or not the inpatient admissions are for the same or related conditions; except that successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the inpatient cost-share payable, provided not more than 60 days have elapsed between the successive admissions. However, notwithstanding this provision, all admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions (refer to section B of this chapter).

(2) Multiple family inpatient admissions. A separate cost-sharing amount is payable for each inpatient admission, regardless of whether or not two or more beneficiary members of a family are admitted at the same time or from the same cause (such as an accident). A separate beneficiary inpatient cost-sharing amount must be applied for each separate admission on each beneficiary member of the family.

(3) Newborn patient in his or her own right. When a newborn infant remains as an inpatient in his or her own right (usually after the mother is discharged), the newborn child becomes the beneficiary and patient and the extended inpatient stay becomes a separate inpatient admission. In such a situation, a new, separate inpatient cost-sharing amount is applied. If a multiple birth is involved (such as twins or triplets) and two or more newborn infants become patients in their own right, a separate inpatient cost-sharing amount must be applied to the inpatient stay for each newborn child who has remained as an inpatient in his or her own right.

c. Outpatient cost-sharing. Dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of 20 percent of the CHAMPUS-determined allowable cost or charge beyond the annual fiscal year deductible amount (as described in paragraph F.1 a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

d. Ambulatory surgery. Notwithstanding the above provisions pertaining to outpatient cost-sharing, dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of \$25 for surgical care that is authorized and received while in an outpatient status and that has been designated in guidelines issued by the Director, OCHAMPUS, or a designee.

3. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees. CHAMPUS beneficiary liability set forth for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. The annual fiscal year deductible for otherwise covered outpatient services or supplies provided retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees, is the same as the annual fiscal year outpatient deductible applicable to dependents of active duty members of rank E-5 or above (refer to paragraph F.2.a.(1) or (2) of this chapter).

b. Inpatient cost-sharing. Cost-sharing amounts for inpatient services shall be as follows:

(1) Services subject to the CHAMPUS DRG-based payment system. The cost-share shall be the lesser of an amount calculated by multiplying a per diem amount for each day of the hospital stay except the day of discharge or 25 percent of the hospital's billed charges. The per diem amount shall be calculated so that total cost-sharing amounts for these beneficiaries is equivalent to 25 percent of the CHAMPUS-determined allowable costs for covered services or supplies provided on an inpatient basis by authorized providers. The per diem amount shall be published annually by CHAMPUS.

(2) Services subject to the mental health per diem payment system. The cost-share is dependent upon whether the hospital is paid a hospital-specific per diem or a regional per diem under the

provisions of subsection A.2. of Chapter 14. With respect to care paid for on the basis of a hospital-specific per diem, the cost-share shall be 25% of the hospital-specific per diem amount. For care paid for on the basis of a regional per diem, the cost share shall be the lower of a fixed daily amount or 25% of the hospital's billed charges. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25 percent of total payments under the mental health per diem payment system. This fixed daily amount shall be updated annually and published in the Federal Register along with the per diems published pursuant to subparagraph A.2.d.(2) of Chapter 14.

(3) Other services. For services exempt from the CHAMPUS DRG-based payment system and the CHAMPUS mental health per diem payment system and services provided by institutions other than hospitals, the cost-share shall be 25% of the CHAMPUS-determined allowable charges.

c. Outpatient cost-sharing. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees are responsible for payment of 25 percent of the CHAMPUS-determined allowable costs or charges beyond the annual fiscal year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

4. Former spouses. CHAMPUS beneficiary liability set forth for former spouses eligible under the provisions of paragraph B.2.b. of Chapter 3 is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. An eligible former spouse is responsible for the payment of the first \$150 of the CHAMPUS-determined reasonable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year. (Except for services received prior to April 1, 1991, the deductible amount is \$50.00). The former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of any CHAMPUS-eligible children.

b. Inpatient cost-sharing. Eligible former spouses are responsible for the payment of cost-sharing amount, the same as those required for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.

c. Outpatient cost-sharing. Eligible former spouses are responsible for payment of 25 percent of the CHAMPUS-determined reasonable costs or charges beyond the annual fiscal year deductible amount for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

5. Cost-Sharing under the Military-Civilian Health Services Partnership Program. Cost-sharing is dependent upon the type of partnership program entered into, whether external or internal. (See section P. of Chapter 1, for general requirements of the Military-Civilian Health Services Partnership Program.)

a. External Partnership Agreement. Authorized costs associated with the use of the civilian facility will be financed through CHAMPUS under the normal cost-sharing and reimbursement procedures applicable under CHAMPUS.

b. Internal Partnership Agreement. Beneficiary cost-share under internal agreements will be the same as charges prescribed for care in military treatment facilities.

6. Amounts over CHAMPUS-determined allowable costs or charges. It is the responsibility of the CHAMPUS fiscal intermediary to determine allowable costs for services and supplies provided by hospitals and other institutions and allowable charges for services and supplies provided by physicians, other individual professional providers, and other providers. Such CHAMPUS-determined allowable costs or charges are made in accordance with the provisions of Chapter 14. All CHAMPUS benefits, including calculation of the CHAMPUS or beneficiary cost-sharing amounts, are based on such CHAMPUS-determined allowable costs or charges. The effect on the beneficiary when the billed cost or charge is over the CHAMPUS-determined allowable amount is dependent upon whether or not the applicable claim was submitted on a participating basis on behalf of the beneficiary or submitted directly by the beneficiary on a nonparticipating basis and on whether the claim is for inpatient hospital services subject to the CHAMPUS DRG-based payment system. This provision applies to all classes of CHAMPUS beneficiaries.

NOTE: When the provider "forgives" or "waives" any beneficiary liability, such as amounts applicable to the annual fiscal year deductible for outpatient services or supplies, or the inpatient or outpatient cost-sharing as previously set forth in this section, the CHAMPUS-determined allowable charge or cost allowance (whether payable to the CHAMPUS beneficiary or sponsor, or to a participating provider) shall be reduced by the same amount.

a. Participating provider. Under CHAMPUS, authorized professional providers and institutional providers other than hospitals have the option of participating on a claim-by-claim basis. Participation is required for inpatient claims only for hospitals which are Medicare-participating providers. Hospitals which are not Medicare-participating but which are subject to the CHAMPUS DRG-based payment system in subsection A.1. of Chapter 14 must sign agreements to participate on all CHAMPUS inpatient claims in order to be authorized providers under CHAMPUS. All other hospitals may elect to participate on a claim-by-claim basis. Participating providers must indicate participation by signing the appropriate space on the applicable CHAMPUS claim form and submitting it to the appropriate CHAMPUS fiscal intermediary. In the case of an institution or medical supplier, the claim must be signed by an official having such authority. This signature certifies that the provider has agreed to accept the CHAMPUS-determined allowable charge or cost as payment in full for the medical services and supplies listed on the specific claim form, and further has agreed to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing amount paid by or on behalf of the beneficiary as full payment for the covered medical services or supplies. Therefore, when costs or charges are submitted on a participating basis, the patient is not obligated to pay any amounts disallowed as being over the CHAMPUS-determined allowable cost or charge for authorized medical services or supplies.

b. Nonparticipating providers. Nonparticipating providers are those providers who do not agree on the CHAMPUS claim form to participate and thereby do not agree to accept the CHAMPUS-determined allowable costs or charges as the full charge. For otherwise covered services and supplies provided by such

nonparticipating CHAMPUS providers, payment is made directly to the beneficiary or sponsor and the beneficiary is liable under applicable law for any amounts over the CHAMPUS-determined allowable costs or charges. CHAMPUS shall have no responsibility for any amounts over allowable costs or charges as determined by CHAMPUS.

7. [Reserved]

8. Cost-sharing for services provided under special discount arrangements.

a. General rule. With respect to services determined by the Director, OCHAMPUS (or designee) to be covered by Chapter 14, section I., the Director, OCHAMPUS (or designee) has authority to establish, as an exception to the cost-sharing amount normally required pursuant to this chapter, a different cost-share amount that appropriately reflects the application of the statutory cost-share to the discount arrangement.

b. Specific applications. The following are examples of applications of the general rule; they are not all inclusive.

(1) In the case of services provided by individual health care professionals and other noninstitutional providers, the cost-share shall be the usual percentage of the CHAMPUS allowable charge determined under Chapter 14, section I.

(2) In the case of services provided by institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under Chapter 14, section A.1. or per-diem amount under Chapter 14, section A.2.), if the discount rate is lower than the pre-set rate, the cost-share amount that would apply for a beneficiary other than an active duty dependent pursuant to the normal pre-set rate would be reduced by the same percentage by which the pre-set rate was reduced in setting the discount rate.

G. EXCLUSIONS AND LIMITATIONS

In addition to any definitions, requirements, conditions, or limitations enumerated and described in other chapters of this Regulation, the following specifically are excluded from the Basic Program:

1. Not medically or psychologically necessary. Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or injury, for the diagnosis and treatment of pregnancy, or for well-baby care.

2. Unnecessary diagnostic tests. X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms.

3. Institutional level of care. Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.

4. Diagnostic admission. Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.

CHAPTER 7
CLAIMS SUBMISSION, REVIEW, AND PAYMENT

A. GENERAL

The Director, OCHAMPUS, or a designee, is responsible for ensuring that benefits under CHAMPUS are paid only to the extent described in this Regulation. Before benefits can be paid, an appropriate claim must be submitted that includes sufficient information as to beneficiary identification, the medical services and supplies provided, and double coverage information, to permit proper, accurate, and timely adjudication of the claim by the CHAMPUS fiscal intermediary or OCHAMPUS. Subject to such definitions, conditions, limitations, exclusions, and requirements as may be set forth in this Regulation, the following are the CHAMPUS claim filing requirements:

1. CHAMPUS identification card required. A patient shall present his or her applicable CHAMPUS identification card (that is, Uniformed Services identification card) to the authorized provider of care that identifies the patient as an eligible CHAMPUS beneficiary (refer to Chapter 3 of this Regulation).
2. Claim required. No benefit may be extended under the Basic Program or PFTH without the submission of a complete and properly executed appropriate claim form.
3. Responsibility for perfecting claim. It is the responsibility of the CHAMPUS beneficiary or sponsor or the authorized provider acting on behalf of the CHAMPUS beneficiary to perfect a claim for submission to the appropriate CHAMPUS fiscal intermediary. Neither a CHAMPUS fiscal intermediary nor OCHAMPUS is authorized to prepare a claim on behalf of a CHAMPUS beneficiary.
4. Obtaining appropriate claim form. CHAMPUS provides specific CHAMPUS forms appropriate for making a claim for benefits for various types of medical services and supplies (such as hospital, physician, or prescription drugs). Claim forms may be obtained from the appropriate CHAMPUS fiscal intermediary who processes claims for the beneficiary's state of residence, from the Director, OCHAMPUS, or a designee, or from CHAMPUS health benefits advisors (HBAs) located at all Uniformed Services medical facilities.
5. Prepayment not required. A CHAMPUS beneficiary or sponsor is not required to pay for the medical services or supplies before submitting a claim for benefits.
6. Deductible certificate. If the fiscal year outpatient deductible, as defined in Chapter 4.F.2, of this regulation, has been met by a beneficiary or a family through the submission of a claim or claims to a CHAMPUS fiscal intermediary in a geographic location different from the location where a current claim is being submitted, the beneficiary or sponsor must obtain a deductible certificate from the CHAMPUS fiscal intermediary where the applicable individual or family fiscal year deductible was met. Such deductible certificate must be attached to the current claim being submitted for benefits. Failure to obtain a deductible certificate under such circumstances will result in a second individual

or family fiscal year deductible being applied. However, this second deductible may be reimbursed once appropriate documentation, as described in this subsection, is supplied to the CHAMPUS fiscal intermediary applying the second deductible (refer to section F.2.(a)(6) of Chapter 4 of this Regulation).

7. Nonavailability Statement (DD Form 1251). In some geographic locations or under certain circumstances, it is necessary for a CHAMPUS beneficiary to determine whether the required medical care can be provided through a Uniformed Services facility. If the required medical care cannot be provided by the Uniformed Services facility, a Nonavailability Statement will be issued. When required (except for emergencies), this Nonavailability Statement must be issued before medical care is obtained from civilian sources. Failure to secure such a statement will waive the beneficiary's rights to benefits under CHAMPUS, subject to appeal to the appropriate hospital commander (or higher medical authority).

a. Rules applicable to issuance of Nonavailability Statement. The ASD(HA) has issued DoD Instruction 6015.19 (reference (gg)) that contains rules for the issuance of Nonavailability Statements. Such rules may change depending on the current situations.

b. Beneficiary responsibility. The beneficiary shall ascertain whether or not he or she resides in a geographic area that requires obtaining a Nonavailability Statement. Information concerning current rules may be obtained from the CHAMPUS fiscal intermediary concerned, a CHAMPUS HBA or the Director, OCHAMPUS, or a designee.

c. Rules in effect at time civilian care is provided apply. The applicable rules regarding Nonavailability Statements in effect at the time the civilian care is rendered apply in determining whether a Nonavailability Statement is required.

d. Nonavailability Statement must be filed with applicable claim. When a claim is submitted for CHAMPUS benefits that includes services for which a Nonavailability Statement is required, such statement must be submitted along with the claim form.

B. INFORMATION REQUIRED TO ADJUDICATE A CHAMPUS CLAIM

Claims received that are not completed fully and that do not provide the following minimum information may be returned. If enough space is not available on the appropriate claim form, the required information must be attached separately and include the patient's name and address, be dated, and signed.

1. Patient's identification information. The following patient identification information must be completed on every CHAMPUS claim form submitted for benefits before a claim will be adjudicated and processed:

- a. Patient's full name.
- b. Patient's residence address.
- c. Patient's date of birth.

DEPARTMENT OF DEFENSE
PUBLICATION SYSTEM

CHANGE TRANSMITTAL

OFFICE OF THE SECRETARY OF DEFENSE
Assistant Secretary of Defense (Health Affairs)

CHANGE NO.2
to July 1991, Reprint
DoD 6010.8-R
October 30, 1991

CIVILIAN HEALTH AND MEDICAL PROGRAM
OF THE UNIFORMED SERVICES (CHAMPUS)

The Assistant Secretary of Defense (Health Affairs), has authorized the following page changes to DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," July 1991 (Reprint).

PAGE CHANGES

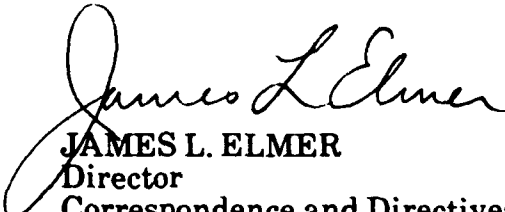
Remove: 2-iii&2-iv, 2-23&2-24, 4-i through 4-iv, 4-vii&4-viii, 4-5&4-6, 4-9 through 4-14, 4-17 through 4-20, 4-50 through 4-55, 6-i&6-ii, 6-3&6-4, 6-12 through 6-13b, 14-i&14-ii, 14-3 through 14-10a, and 14-21 through 14-23

Insert: Attached replacement pages and new pages 4-6a&4-6b, 4-9a&4-9b, 4-12a&4-12b, 4-13a&4-13b, 14-3 through 14-10a, and 14-24 through 14-26

Changes appear on pages 2-iv, 2-23, 4-i through 4-iii, 4-vii, 4-viii, 4-5&4-6, 4-9 through 4-12, 4-18, 4-19, 4-50, 4-52, 4-53, 4-55, 6-i, 6-3, 6-12 through 6-13a and are indicated by marginal bars. Pages 14-3 through 14-10a to Change No. 24, March 1987, were inadvertently omitted from the July 1991 (Reprint). Changes also appear on pages 14-i&14-ii, 14-21 through 14-23 and are indicated by marginal asterisks.

EFFECTIVE DATE

The above changes are effective immediately.


JAMES L. ELMER
Director
Correspondence and Directives

Attachments
61 pages

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, THIS TRANSMITTAL SHOULD BE FILED WITH THE BASIC DOCUMENT

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Prosthetic Device (Prosthesis). An artificial substitute for a missing body part.

Provider. A hospital or other institutional provider, a physician, or other individual professional provider, or other provider of services or supplies as specified in Chapter 6 of this Regulation.

Provider Exclusion and Suspension. The terms "exclusion" and "suspension", when referring to a provider under CHAMPUS, both mean the denial of status as an authorized provider, resulting in items, services, or supplies furnished by the provider not being reimbursed, directly or indirectly, under CHAMPUS. The terms may be used interchangeably to refer to a provider who has been denied status as an authorized CHAMPUS provider based on 1) a criminal conviction or civil judgment involving fraud, 2) an administrative finding of fraud or abuse under CHAMPUS, 3) an administrative finding that the provider has been excluded or suspended by another agency of the Federal Government, a state, or a local licensing authority, 4) an administrative finding that the provider has knowingly participated in a conflict of interest situation, or 5) an administrative finding that it is in the best interests of the CHAMPUS or CHAMPUS beneficiaries to exclude or suspend the provider.

Provider Termination. When a provider's status as an authorized CHAMPUS provider is ended, other than through exclusion or suspension, based on a finding that the provider does not meet the qualifications, as set forth in Chapter 6 of this Regulation, to be an authorized CHAMPUS provider.

Psychiatric emergency. A psychiatric inpatient admission is an emergency when, based on a psychiatric evaluation performed by a physician (or other qualified mental health care professional with hospital admission authority), the patient is at immediate risk of serious harm to self or others as a result of a mental disorder and requires immediate continuous skilled observation at the acute level of care.

Radiation Therapy Services. The treatment of diseases by x-ray, radium, or radioactive isotopes when ordered by the attending physician.

Referral. The act or an instance of referring a CHAMPUS beneficiary to another authorized provider to obtain necessary medical treatment. Under CHAMPUS, only a physician may make referrals.

Registered Nurse. A person who is prepared specially in the scientific basis of nursing, who is a graduate of a school of nursing, and who is registered for practice after examination by a state board of nurse examiners or similar regulatory authority, who holds a current, valid license, and who is entitled legally to use the designation R.N.

Representative. Any person who has been appointed by a party to the initial determination as counsel or advisor and who is otherwise eligible to serve as the counsel or advisor of the party to the initial determination, particularly in connection with a hearing.

Resident (Medical). A graduate physician or dentist who has an M.D. or D.O. degree, or D.D.S. or D.M.D. degree, respectively, is licensed to practice, and who chooses to remain on the house staff of a hospital to get further training that will qualify him or her for a medical or dental specialty.

Residential Treatment Center (RTC). A facility (or distinct part of a facility) which meets the criteria in Chapter 6.B.4.

Retiree. A member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay based on duty in a Uniformed Service.

Routine Eye Examinations. The services rendered in order to determine the refractive state of the eyes.

Sanction. For purpose of Chapter 9, "sanction" means a provider exclusion, suspension, or termination.

Secondary Payer. The plan or program whose medical benefits are payable in double coverage situations only after the primary payer has adjudicated the claim.

Semiprivate Room. A room containing at least two beds. If a room is designated publicly as a semiprivate accommodation by the hospital or other authorized institutional provider and contains multiple beds, it qualifies as a semiprivate room for the purposes of CHAMPUS.

Skilled Nursing Facility. An institution (or a distinct part of an institution) that meets the criteria as set forth in subsection B.4. of Chapter 6 of this Regulation.

Skilled Nursing Service. A service that can only be furnished by an R.N., or L.P.N. or L.V.N., and is required to be performed under the supervision of a physician to ensure the safety of the patient and achieve the medically desired result. Examples of skilled nursing services are intravenous or intramuscular injections, levin tube or gastrostomy feedings, or tracheotomy aspiration and insertion. Skilled nursing services are other than those services that provide primarily support for the essentials of daily living or that could be performed by an untrained adult with minimum instruction or supervision.

Special Tutoring. Teaching or instruction provided by a private teacher to an individual usually in a private or separate setting to enhance the educational development of an individual in one or more study areas.

Spectacles, Eyeglasses, and Lenses. Lenses, including contact lenses, that help to correct faulty vision.

Sponsor. An active duty member, retiree, or deceased active duty member or retiree, of a Uniformed Service upon whose status his or her dependents' eligibility for CHAMPUS is based.

Spouse. A lawful wife or husband regardless of whether or not dependent upon the active duty member or retiree.

CHAPTER 4

BASIC PROGRAM BENEFITS

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c. Documentation for preauthorization - approved treatment plan.
A request for preauthorization described in subsection A.11. of this chapter, requires submission of a detailed treatment plan, in accordance with guidelines and procedures issued by the Director, OCHAMPUS.

d. Other preauthorization requirements

(1) The Director, OCHAMPUS, or a designee, shall respond to all requests for preauthorization in writing and shall send notification of approval or denial to the beneficiary.

(2) The Director, OCHAMPUS, or a designee, shall specify, in the approved preauthorization, the services and supplies the approval covers.

(3) An approved preauthorization is valid only for 90 days from the date of issuance. If the preauthorized services and supplies are not obtained or commenced within the 90-day period, a new preauthorization request is required.

(4) A preauthorization may set forth other special limits or requirements as indicated by the particular case or situation for which preauthorization is being issued.

12. Utilization review, quality assurance and preauthorization for inpatient mental health services.

a. In general. The Director, OCHAMPUS shall provide, either directly or through contract, a program of utilization and quality review for all mental health care services. Among other things, this program shall include mandatory preadmission authorization before nonemergency inpatient mental health services may be provided and mandatory approval of continuation of inpatient services within 72 hours of emergency admissions. This program shall also include requirements for other pretreatment authorization procedures, concurrent review of continuing inpatient and outpatient care, retrospective review, and other such procedures as determined appropriate by the Director, OCHAMPUS. The provisions of paragraph H of this chapter and paragraph F, Chapter 15, shall apply to this program. The Director, OCHAMPUS, shall establish, pursuant to paragraph F., Chapter 15, procedures substantially comparable to requirements of paragraph H of this chapter and Chapter 15. If the utilization and quality review program for mental health care services is provided by contract, the contractor(s) need not be the same contractor(s) as are engaged under Chapter 15 in connection with the review of other services.

b. Preadmission authorization.

(1) This section generally requires preadmission authorization for all nonemergency inpatient mental health services and prompt continued stay authorization after emergency admissions. Institutional services for which payment would otherwise be authorized, but which were provided without compliance with preadmission authorization requirements, do not qualify for the same payment that would be provided if the preadmission requirements had been met.

(2) In cases of noncompliance with preadmission authorization requirements, institutional payment will be reduced by the amount attributable to the days of services without the appropriate certification up to a maximum of five days of services. In cases in which payment is determined on a prospectively set per-discharge basis (such as the DRG-based payment system), the reduction shall be \$500 for each day of services provided without the appropriate preauthorization, up to a maximum of five days of services.

(3) For purposes of paragraph A.12.b.(2) of this chapter, a day of services without the appropriate preauthorization is any day of services provided prior to:

(a) the receipt of an authorization; or

(b) the effective date of an authorization subsequently received.

(4) Services for which payment is disallowed under paragraph A.12.b.(2) of this chapter may not be billed to the patient (or the patient's family).

13. Implementing instructions. The Director, OCHAMPUS, or a designee, shall issue policies, instructions, procedures, guidelines, standards, or criteria as may be necessary to implement the intent of this Regulation.

B. INSTITUTIONAL BENEFITS

1. General. Services and supplies provided by an institutional provider authorized as set forth in Chapter 6 of this Regulation may be cost-shared only when such services or supplies (i) are otherwise authorized by this Regulation; (ii) are medically necessary; (iii) are ordered, directed, prescribed, or delivered by an OCHAMPUS-authorized individual professional provider as set forth in Chapter 6 of this Regulation or by an employee of the authorized institutional provider who is otherwise eligible to be a CHAMPUS authorized individual professional provider; (iv) are delivered in accordance with generally accepted norms for clinical practice in the United States; (v) meet established quality standards; and (vi) comply with applicable definitions, conditions, limitations, exceptions, or exclusions as otherwise set forth in this Regulation.

a. Billing practices. To be considered for benefits under this section B., covered services and supplies must be provided and billed for by a hospital or other authorized institutional provider. Such billings must be fully itemized and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. In the case of continuous care, claims shall be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor or, on a participating basis, directly by the facility on behalf of the beneficiary (refer to Chapter 7).

b. Successive inpatient admissions. Successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the active duty dependent's share of the inpatient institutional charges, provided not more than 60 days have elapsed between the successive admissions, except that successive inpatient admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions. For the purpose of applying benefits, successive admissions will be determined separately for maternity admissions and admissions related to an accidental injury (refer to section F. of this chapter).

c. Related services and supplies. Covered services and supplies must be rendered in connection with and related directly to a covered diagnosis or definitive set of symptoms requiring otherwise authorized medically necessary treatment.

d. Inpatient, appropriate level required. For purposes of inpatient care, the level of institutional care for which Basic Program benefits may be extended must be at the appropriate level required to provide the medically necessary treatment. If an appropriate lower level care facility is adequate, but is not available in the general locality, benefits may be continued in the higher level care facility, but CHAMPUS institutional benefit payments shall be limited to the allowable cost that would have been incurred in the appropriate lower level care facility, as determined by the Director, OCHAMPUS, or a designee. If it is determined that the institutional care can be provided reasonably in the home setting, no CHAMPUS institutional benefits are payable.

e. General or special education not covered. Services and supplies related to the provision of either regular or special education generally are not covered. Such exclusion applies whether a separate charge is made for education or whether it is included as a part of an overall combined daily charge of an institution. In the latter instance, that portion of the overall combined daily charge related to education must be determined, based on the allowable costs of the educational component, and deleted from the institution's charges before CHAMPUS benefits can be extended. The only exception is when appropriate education is not available from or not payable by the cognizant public entity. Each case must be referred to the Director, OCHAMPUS, or a designee, for review and a determination of the applicability of CHAMPUS benefits.

2. Covered hospital services and supplies

a. Room and board. Includes special diets, laundry services, and other general housekeeping support services (inpatient only).

b. General staff nursing services.

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k. Chemotherapy.

l. Psychological evaluation tests. When required by the diagnosis.

m. Renal and peritoneal dialysis.

n. Other medical services. Other medical services may be authorized by the Director, OCHAMPUS, or a designee, provided they are related directly to the diagnosis or definitive set of symptoms and rendered by a member of the institution's medical or professional staff (either salaried or contractual) and billed for by the authorized institutional provider of care.

4. Services and supplies provided by RTCs

a. Room and board. Includes use of residential facilities such as food service (including special diets), laundry services, supervised reasonable recreational and social activity services, and other general services as considered appropriate by the Director, OCHAMPUS, or a designee.

b. Patient assessment. Includes the assessment of each child or adolescent accepted by the RTC, including clinical consideration of each of his or her fundamental needs, that is, physical, psychological, chronological age, developmental level, family, educational, social, environmental, and recreational.

c. Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results.

d. Psychological evaluation tests.

e. Treatment of mental disorders. Services and supplies that are medically or psychologically necessary to diagnose and treat the mental disorder for which the patient was admitted to the RTC. Covered services and requirements for qualifications of providers are as listed in paragraph C.3.i. of this chapter.

f. Other necessary medical care. Emergency medical services or other authorized medical care may be rendered by the RTC provided it is professionally capable of rendering such services and meets standards required by the Director, OCHAMPUS. It is intended, however, that CHAMPUS payments to an RTC should primarily cover those services and supplies directly related to the treatment of mental disorders that require residential care.

g. Criteria for determining medical or psychological necessity. In determining the medical or psychological necessity of services and supplies provided by RTCs, the evaluation conducted by the Director, OCHAMPUS (or designee) shall consider the appropriate level of care for the patient, the intensity of services required by the patient, and the availability of that care. In addition to the criteria set forth in this paragraph B.4. of this chapter, additional evaluation standards, consistent with such criteria, may be

adopted by the Director, OCHAMPUS (or designee). RTC services and supplies shall not be considered medically or psychologically necessary unless, at a minimum, all the following criteria are clinically determined in the evaluation to be fully met:

- (1) Patient has a diagnosable psychiatric disorder.
- (2) Patient exhibits patterns of disruptive behavior with evidence of disturbances in family functioning or social relationships and persistent psychological and/or emotional disturbances.
- (3) RTC services involve active clinical treatment under an individualized treatment plan that provides for:
 - (a) Specific level of care, and measurable goals/objectives relevant to each of the problems identified;
 - (b) Skilled interventions by qualified mental health professionals to assist the patient and/or family;
 - (c) Time frames for achieving proposed outcomes; and
 - (d) Evaluation of treatment progress to include timely reviews and updates as appropriate of the patient's treatment plan that reflects alterations in the treatment regimen, the measurable goals/objectives, and the level of care required for each of the patient's problems, and explanations of any failure to achieve the treatment goals/objectives.
- (4) Unless therapeutically contraindicated, the family and/or guardian must actively participate in the continuing care of the patient either through direct involvement at the facility or geographically distant family therapy. (In the latter case, the treatment center must document that there has been collaboration with the family and/or guardian in all reviews.)

h. Preauthorization requirement.

- (1) All admissions to RTC care are elective and must be certified as medically/psychologically necessary prior to admission. The criteria for preauthorization shall be those set forth in paragraph B.4.g. of this chapter. In applying those criteria in the context of preadmission authorization review, special emphasis is placed on the development of a specific diagnosis/treatment plan, consistent with those criteria and reasonably expected to be effective, for that individual patient.
- (2) The timetable for development of the individualized treatment plan shall be as follows:
 - (a) The plan must be under development at the time of the admission.

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(b) A preliminary treatment plan must be established within 24 hours of the admission.

(c) A master treatment plan must be established within ten calendar days of the admission.

(3) The elements of the individualized treatment plan must include:

(a) The diagnostic evaluation that establishes the necessity for the admission;

(b) An assessment regarding the inappropriateness of services at a less intensive level of care;

(c) A comprehensive, biopsychosocial assessment and diagnostic formulation;

(d) A specific individualized treatment plan that integrates measurable goals/objectives and their required level of care for each of the patient's problems that are a focus of treatment;

(e) A specific plan for involvement of family members, unless therapeutically contraindicated; and

(f) A discharge plan, including an objective of referring the patient to further services, if needed, at less intensive levels of care within the benefit limit period.

(4) Preauthorization requests should be made not less than two business days prior to the planned admission. In general, the decision regarding preauthorization shall be made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. Preauthorizations are valid for 90 days.

i. Concurrent review. Concurrent review of the necessity for continued stay will be conducted no less frequently than every 30 days. The criteria for concurrent review shall be those set forth in paragraph B.4.g. of this chapter. In applying those criteria in the context of concurrent review, special emphasis is placed on evaluating the progress being made in the active individualized clinical treatment being provided and on developing appropriate discharge plans.

5. Extent of institutional benefits

a. Inpatient room accommodations

(1) Semiprivate. The allowable costs for room and board furnished an individual patient are payable for semiprivate accommodations in a hospital or other authorized institution, subject to appropriate cost-sharing

provisions (refer to section F. of this chapter). A semiprivate accommodation is a room containing at least two beds. Therefore, if a room publicly is designated by the institution as a semiprivate accommodation and contains multiple beds, it qualifies as semiprivate for the purpose of CHAMPUS.

(2) Private. A room with one bed that is designated as a private room by the hospital or other authorized institutional provider. The allowable cost of a private room accommodation is covered only under the following conditions:

(a) When its use is required medically and when the attending physician certifies that a private room is necessary medically for the proper care and treatment of a patient; or

(b) When a patient's medical condition requires isolation;
or

(c) When a patient (in need of immediate inpatient care but not requiring a private room) is admitted to a hospital or other authorized institution that has semiprivate accommodations, but at the time of admission, such accommodations are occupied; or

(d) When a patient is admitted to an acute care hospital (general or special) without semiprivate rooms.

(3) Duration of private room stay. The allowable cost of private accommodations is covered under the circumstances described in subparagraph B.5.a.(2) of this chapter until the patient's condition no longer requires the private room for medical reasons or medical isolation; or, in the case of the patient not requiring a private room, when a semiprivate accommodation becomes available; or, in the case of an acute care hospital (general or special) which does not have semiprivate rooms, for the duration of an otherwise covered inpatient stay.

(4) Hospital (except an acute care hospital, general or special) or other authorized institutional provider without semiprivate accommodations. When a beneficiary is admitted to a hospital (except an acute care hospital, general or special) or other institution that has no semiprivate accommodations, for any inpatient day when the patient qualifies for use of a private room (as set forth in subparagraphs B.5.a.(2)(a) and (b), above), the allowable cost of private accommodations is covered. For any inpatient day in such a hospital or other authorized institution when the patient does not require medically the private room, the allowable cost of semiprivate accommodations is covered, such allowable costs to be determined by the Director, OCHAMPUS, or a designee.

b. General staff nursing services. General staff nursing services cover all nursing care (other than that provided by private duty nurses) including, but not limited to, general duty nursing, emergency room nursing, recovery room nursing, intensive nursing care, and group nursing arrangements. Only nursing services provided by nursing personnel on the payroll of the hospital or other authorized institution are eligible under this section B. If a nurse who is not on the payroll of the hospital or other

authorized institution is called in specifically to care for a single patient (individual nursing) or more than one patient (group nursing), whether the patient is billed for the nursing services directly or through the hospital or other institution, such services constitute private duty (special) nursing services and are not eligible for benefits under this paragraph (the provisions of paragraph C.2.o. of this chapter would apply).

c. ICU. An ICU is a special segregated unit of a hospital in which patients are concentrated, by reason of serious illness, usually without regard to diagnosis. Special lifesaving techniques and equipment are available regularly and immediately within the unit, and patients are under continuous observation by a nursing staff specially trained and selected for the care of this type of patient. The unit is maintained on a continuing, rather than an intermittent or temporary, basis. It is not a postoperative recovery room or a postanesthesia room. In some large or highly specialized hospitals, the ICUs may be refined further for special purposes, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery. For purposes of CHAMPUS, these specialized units would be considered ICUs if they otherwise conformed to the definition of an ICU.

d. Treatment rooms. Standard treatment rooms include emergency rooms, operating rooms, recovery rooms, special treatment rooms, and hyperbaric chambers and all related necessary medical staff and equipment. To be recognized for purposes of CHAMPUS, treatment rooms must be so designated and maintained by the hospital or other authorized institution on a continuing basis. A treatment room set up on an intermittent or temporary basis would not be so recognized.

e. Drugs and medicines. Drugs and medicines are included as a supply of a hospital or other authorized institution only under the following conditions:

- (1) They represent a cost to the facility rendering treatment;
- (2) They are furnished to a patient receiving treatment, and are related directly to that treatment; and
- (3) They are ordinarily furnished by the facility for the care and treatment of inpatients.

f. Durable medical equipment, medical supplies, and dressings. Durable medical equipment, medical supplies, and dressings are included as a supply of a hospital or other authorized institution only under the following conditions:

- (1) If ordinarily furnished by the facility for the care and treatment of patients; and
- (2) If specifically related to, and in connection with, the condition for which the patient is being treated; and

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(3) If ordinarily furnished to a patient for use in the hospital or other authorized institution (except in the case of a temporary or disposable item); and

(4) Use of durable medical equipment is limited to those items provided while the patient is an inpatient. If such equipment is provided for use on an outpatient basis, the provisions of section D. of this chapter apply.

g. Transitional use items. Under certain circumstances, a temporary or disposable item may be provided for use beyond an inpatient stay, when such item is necessary medically to permit or facilitate the patient's departure from the hospital or other authorized institution, or which may be required until such time as the patient can obtain a continuing supply; or it would be unreasonable or impossible from a medical standpoint to discontinue the patient's use of the item at the time of termination of his or her stay as an inpatient.

h. Anesthetics and oxygen. Anesthetics and oxygen and their administration are considered a service or supply if furnished by the hospital or other authorized institution, or by others under arrangements made by the facility under which the billing for such services is made through the facility.

6. Inpatient mental health services. Inpatient mental health services are those services furnished by institutional and professional providers for treatment of a nervous or mental disorder (as defined in Chapter 2) to a patient admitted to a CHAMPUS-authorized acute care general hospital; a psychiatric hospital; or, unless otherwise exempted, a specialized treatment facility.

a. Criteria for determining medical or psychological necessity. In determining the medical or psychological necessity of acute inpatient mental health services, the evaluation conducted by the Director, OCHAMPUS (or designee) shall consider the appropriate level of care for the patient, the intensity of services required by the patient, and the availability of that care. The purpose of such acute inpatient care is to stabilize a life-threatening or severely disabling condition within the context of a brief, intensive model of inpatient care in order to permit management of the patient's condition at a less intensive level of care. Such care is appropriate only if the patient requires services of an intensity and nature that are generally recognized as being effectively and safely provided only in an acute inpatient hospital setting. In addition to the criteria set forth in this paragraph B.6. of this chapter, additional evaluation standards, consistent with such criteria, may be adopted by the Director, OCHAMPUS (or designee). Acute inpatient care shall not be considered necessary unless the patient needs to be observed and assessed on a 24-hour basis by skilled nursing staff, and/or requires continued intervention by a multidisciplinary treatment team; and in addition, at least one of the following criteria is determined to be met:

- (1) Patient poses a serious risk of harm to self and/or others.
- (2) Patient is in need of high dosage, intensive medication or somatic and/or psychological treatment, with potentially serious side effects.
- (3) Patient has acute disturbances of mood, behavior, or thinking.

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b. Emergency admissions. Admission to an acute inpatient hospital setting may be on an emergency or on a non-emergency basis. In order for an admission to qualify as an emergency, the following criteria, in addition to those in paragraph B.6.a. of this chapter, must be met:

(1) the patient must be at immediate risk of serious harm to self and or others based on a psychiatric evaluation performed by a physician (or other qualified mental health professional with hospital admission authority); and

(2) the patient requires immediate continuous skilled observation and treatment at the acute psychiatric level of care.

c. Preauthorization requirements.

(1) All non-emergency admissions to an acute inpatient hospital level of care must be authorized prior to the admission. The criteria for preauthorization shall be those set forth in paragraph B.6.a. of this chapter. In applying those criteria in the context of preauthorization review, special emphasis is placed on the development of a specific individualized treatment plan, consistent with those criteria and reasonably expected to be effective, for that individual patient.

(2) The timetable for development of the individualized treatment plan shall be as follows:

(a) The development of the plan must begin immediately upon admission.

(b) A preliminary treatment plan must be established within 24 hours of the admission.

(c) A master treatment plan must be established within five calendar days of the admission.

(3) The elements of the individualized treatment plan must include:

(a) The diagnostic evaluation that establishes the necessity for the admission;

(b) An assessment regarding the inappropriateness of services at a less intensive level of care;

(c) A comprehensive biopsychosocial assessment and diagnostic formulation;

(d) A specific individualized treatment plan that integrates measurable goals/objectives and their required level of care for each of the patient's problems that are a focus of treatment;

(e) A specific plan for involvement of family members, unless therapeutically contraindicated; and

(f) A discharge plan, including an objective of referring the patient to further services, if needed, at less intensive levels of care within the benefit limit period.

(4) The request for preauthorization must be received by the reviewer designated by the Director, OCHAMPUS prior to the planned admission. In general, the decision regarding preauthorization shall be made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. In the case of an authorization issued after an admission resulting from approval of a request made prior to the admission, the effective date of the certification shall be the date of the receipt of the request. However, if the request on which the approved authorization is based was made after the admission (and the case was not an emergency admission), the effective date of the authorization shall be the date of approval.

(5) Authorization prior to admission is not required in the case of a psychiatric emergency requiring an inpatient acute level of care, but authorization for a continuation of services must be obtained promptly. Admissions resulting from a bona fide psychiatric emergency should be reported within 24 hours of the admission or the next business day after the admission, but must be reported to the Director, OCHAMPUS or a designee, within 72 hours of the admission. In the case of an emergency admission authorization resulting from approval of a request made within 72 hours of the admission, the effective date of the authorization shall be the date of the admission. However, if it is determined that the case was not a bona fide psychiatric emergency admission (but the admission can be authorized as medically or psychologically necessary), the effective date of the authorization shall be the date of the receipt of the request.

d. Concurrent review. Concurrent review of the necessity for continued stay will be conducted. The criteria for concurrent review shall be those set forth in paragraph B.6.a. of this chapter. In applying those criteria in the context of concurrent review, special emphasis is placed on evaluating the progress being made in the active clinical treatment being provided and on developing/refining appropriate discharge plans. In general, the decision regarding concurrent review shall be made within one business day of the review, and shall be followed with written confirmation.

7. Emergency inpatient hospital services. In the case of a medical emergency, benefits can be extended for medically necessary inpatient services and supplies provided to a beneficiary by a hospital, including hospitals that do not meet CHAMPUS standards or comply with the provisions of title VI of the Civil Rights Act (reference (z)), or satisfy other conditions herein set forth. In a medical emergency, medically necessary inpatient services and supplies are those that are necessary to prevent the death or serious impairment of the health of the patient, and that, because of the threat to the life or health of the patient, necessitate, the use of the most accessible hospital available and equipped to furnish such services. The availability of benefits depends upon the following three separate findings and continues only as long as the emergency exists, as determined by medical review. If the case qualified as an emergency at the time of admission to an unauthorized institutional provider and the emergency subsequently is determined no longer to exist, benefits will be extended up through the date of notice to the beneficiary and provider that CHAMPUS benefits no longer are payable in that hospital.

a. Existence of medical emergency. A determination that a medical emergency existed with regard to the patient's condition;

b. Immediate admission required. A determination that the condition causing the medical emergency required immediate admission to a hospital to provide the emergency care; and

c. Closest hospital utilized. A determination that diagnosis or treatment was received at the most accessible (closest) hospital available and equipped to furnish the medically necessary care.

8. RTC day limit.

a. With respect to mental health services provided on or after October 1, 1991, benefits for residential treatment are generally limited to 150 days in a fiscal year or 150 days in an admission (not including days of care prior to October 1, 1991). The RTC benefit limit is separate from the benefit limit for acute inpatient mental health care.

b. Waiver of the RTC day limit.

(1) There is a statutory presumption against the appropriateness of residential treatment services in excess of the 150 day limit. However, the Director, OCHAMPUS, (or designee) may in special cases, after considering the opinion of the peer review designated by the Director (involving a health professional who is not a federal employee) confirming that applicable criteria have been met, waive the RTC benefit limit in paragraph B.8.a. of this chapter and authorize payment for care beyond that limit.

(2) The criteria for waiver shall be those set forth in paragraph B.4.g. of this chapter. In applying those criteria to the context of waiver request reviews, special emphasis is placed on assuring that the record documents that:

(a) Active treatment has taken place for the past 150 days and substantial progress has been made according to the plan of treatment.

(b) The progress made is insufficient, due to the complexity of the illness, for the patient to be discharged to a less intensive level of care.

(c) Specific evidence is presented to explain the factors which interfered with treatment progress during the 150 days of RTC care.

(d) The waiver request includes specific time frames and a specific plan of treatment which will lead to discharge.

(3) Where family or social issues complicate transfer to a lower level of intensity, the RTC is responsible for determining and arranging the supportive and adjunctive resources required to permit appropriate transfer. If the RTC fails adequately to meet this responsibility, the existence of such family or social issues shall be an inadequate basis for a waiver of the benefit limit.

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(4) It is the responsibility of the patient's attending clinician to establish, through actual documentation from the medical record and other sources, that the conditions for waiver exist.

c. RTC day limits do not apply to services provided under the Program for the Handicapped (Chapter 5 of this Regulation) or services provided as partial hospitalization care.

9. Acute care day limits.

a. With respect to mental health care services provided on or after October 1, 1991, payment for inpatient acute hospital care is, in general, statutorily limited as follows:

(1) Adults, aged 19 and over - 30 days in a fiscal year or 30 days in an admission (excluding days provided prior to October 1, 1991).

(2) Children and adolescents, aged 18 and under - 45 days in a fiscal year or 45 days in an admission (excluding days provided prior to October 1, 1991).

b. It is the patient's age at the time of admission that determines the number of days available.

c. Waiver of the acute care day limits.

(1) There is a statutory presumption against the appropriateness of inpatient acute services in excess of the day limits set forth in paragraph B.9.a. of this chapter. However, the Director, OCHAMPUS (or designee) may in special cases, after considering the opinion of the peer review designated by the Director (involving a health professional who is not a federal employee) confirming that applicable criteria have been met, waive the acute inpatient limits described in paragraph B.9.a. of this chapter and authorize payment for care beyond those limits.

(2) The criteria for waiver of the acute inpatient limit shall be those set forth in paragraph B.6.a. of this chapter. In applying those criteria in the context of waiver request review, special emphasis is placed on determining whether additional days of acute inpatient mental health care are medically/psychologically necessary to complete necessary elements of the treatment plan prior to implementing appropriate discharge planning. A waiver may also be granted in cases in which a patient exhibits well-documented new symptoms, maladaptive behavior, or medical complications which have appeared in the inpatient setting requiring a significant revision to the treatment plan.

(3) The clinician responsible for the patient's care is responsible for documenting that a waiver criterion has been met and must establish an estimated length of stay beyond the date of the inpatient limit. There must be evidence of a coherent and specific plan for assessment, intervention and reassessment that reasonably can be accomplished within the time frame of the additional days of coverage requested under the waiver provision.

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(4) For patients in care at the time the inpatient limit is reached, a waiver must be requested prior to the limit. For patients being readmitted after having received 30 or 45 days in the fiscal year, the waiver review will be conducted at the time of the preadmission authorization.

d. Acute care day limits do not apply to services provided under the Program for the Handicapped (Chapter 5 of this Regulation) or services provided as partial hospitalization care.

C. PROFESSIONAL SERVICES BENEFIT

1. General. Benefits may be extended for those covered services described in this section C., that are provided in accordance with good medical practice and established standards of quality by physicians or other authorized individual professional providers, as set forth in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, exceptions, limitations, or exclusion as may be otherwise set forth

in this or other chapters of this Regulation. Except as otherwise specifically authorized, to be considered for benefits under this section C., the described services must be rendered by a physician, or prescribed, ordered, and referred medically by a physician to other authorized individual professional providers. Further, except under specifically defined circumstances, there should be an attending physician in any episode of care. (For example, certain services of a clinical psychologist are exempt from this requirement. For these exceptions, refer to Chapter 6.)

a. Billing practices. To be considered for benefits under this section C., covered professional services must be performed personally by the physician or other authorized individual professional provider, who is other than a salaried or contractual staff member of a hospital or other authorized institution, and who ordinarily and customarily bills on a fee-for-service basis for professional services rendered. Such billings must be itemized fully and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. For continuing professional care, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor, or directly by the physician or other authorized individual professional provider on behalf of a beneficiary (refer to Chapter 7 of this Regulation).

b. Services must be related. Covered professional services must be rendered in connection with and directly related to a covered diagnosis or definitive set of symptoms requiring medically necessary treatment.

2. Covered services of physicians and other authorized individual professional providers

a. Surgery. Surgery means operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and the following procedures:

- Bronchoscopy
- Laryngoscopy
- Thoracoscopy
- Catheterization of the heart
- Arteriograph thoracic lumbar
- Esophagoscopy
- Gastrosocopy
- Proctoscopy
- Sigmoidoscopy
- Peritoneoscopy
- Cystoscopy
- Colonoscopy
- Upper G.I. panendoscopy
- Encephalograph
- Myelography
- Discography
- Visualization of intracranial aneurysm by intracarotid injection of dye, with exposure of carotid artery, unilateral

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c. Need for surgical assistance. Surgical assistance is payable only when the complexity of the procedure warrants a surgical assistant (other than the surgical nurse or other such operating room personnel), subject to utilization review. In order for benefits to be extended for surgical assistance service, the primary surgeon may be required to certify in writing to the nonavailability of a qualified intern, resident, or other house physician. When a claim is received for a surgical assistant involving the following circumstances, special review is required to ascertain whether the surgical assistance service meets the medical necessity and other requirements of this section C.

(1) If the surgical assistance occurred in a hospital that has a residency program in a specialty appropriate to the surgery;

(2) If the surgery was performed by a team of surgeons;

(3) If there were multiple surgical assistants; or

(4) If the surgical assistant was a partner of or from the same group of practicing surgeons as the attending surgeon.

d. Aftercare following surgery. Except for those diagnostic procedures classified as surgery in this section C., and injection and needling procedures involving the joints, the benefit payments made for surgery (regardless of the setting in which it is rendered) include normal aftercare, whether the aftercare is billed for by the physician or other authorized individual professional provider on a global, all-inclusive basis, or billed for separately.

e. Cast and sutures, removal. The benefit payments made for the application of a cast or of sutures normally covers the postoperative care including the removal of the cast or sutures. When the application is made in one geographical location and the removal of the cast or sutures must be done in another geographical location, a separate benefit payment may be provided for the removal. The intent of this provision is to provide a separate benefit only when it is impracticable for the beneficiary to use the services of the provider that applied the cast originally. Benefits are not available for the services of a second provider if those services reasonably could have been rendered by the individual professional provider who applied the cast or sutures initially.

f. Inpatient care, concurrent. Concurrent inpatient care by more than one individual professional provider is covered if required because of the severity and complexity of the beneficiary's condition or because the beneficiary has multiple conditions that require treatment by providers of different specialties. Any claim for concurrent care must be reviewed before extending benefits in order to ascertain the condition of the beneficiary at the time the concurrent care was rendered. In the absence of such determination, benefits are payable only for inpatient care rendered by one attending physician or other authorized individual professional provider.

g. Consultants who become the attending surgeon. A consultation performed within 3 days of surgery by the attending physician is considered a preoperative examination. Preoperative examinations are an integral part of the surgery and a separate benefit is not payable for the consultation. If more than 3 days elapse between the consultation and surgery (performed by the same physician), benefits may be extended for the consultation, subject to review.

h. Anesthesia administered by the attending physician. A separate benefit is not payable for anesthesia administered by the attending physician (surgeon or obstetrician) or dentist, or by the surgical, obstetrical, or dental assistant.

i. Treatment of mental disorders. CHAMPUS benefits for the treatment of mental disorders are payable for beneficiaries who are outpatients or inpatients of CHAMPUS-authorized general or psychiatric hospitals, RTCs, or specialized treatment facilities, as authorized by the Director, OCHAMPUS, or a designee. All such services are subject to review for medical or psychological necessity and for quality of care. The Director, OCHAMPUS, reserves the right to require preauthorization of mental health services. Preauthorization may be conducted by the Director, OCHAMPUS, or a designee. In order to qualify for CHAMPUS mental health benefits, the patient must be diagnosed by a CHAMPUS-authorized licensed, qualified mental health professional to be suffering from a mental disorder, according to the criteria listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Benefits are limited for certain mental disorders, such as specific developmental disorders. No benefits are payable for "Conditions Not Attributable to a Mental Disorder," or V codes. In order for treatment of a mental disorder to be medically or psychologically necessary, the patient must, as a result of a diagnosed mental disorder, be experiencing both physical or psychological distress and an impairment in his or her ability to function in appropriate occupational, educational or social roles. It is generally the degree to which the patient's ability to function is impaired that determines the level of care (if any) required to treat the patient's condition.

(1) Covered diagnostic and therapeutic services. Subject to the requirements and limitations stated, CHAMPUS benefits are payable for the following services when rendered in the diagnosis or treatment of a covered mental disorder by a CHAMPUS-authorized, qualified mental health provider practicing within the scope of his or her license. Qualified mental health providers are: psychiatrists or other physicians; clinical psychologists, certified psychiatric nurse specialists or clinical social workers; and marriage and family, pastoral, and mental health counselors, under a physician's supervision. No payment will be made for any service listed in this subparagraph C.3.i.(1) rendered by an individual who does not meet the criteria of Chapter 6 of this Regulation for his or her respective profession, regardless of whether the provider is an independent professional provider or an employee of an authorized professional or institutional provider.

(a) Individual psychotherapy, adult or child. A covered individual psychotherapy session is no more than 60 minutes in length. An individual psychotherapy session of up to 120 minutes in length is payable for crisis intervention.

(b) Group psychotherapy. A covered group psychotherapy session is no more than 90 minutes in length.

(c) Family or conjoint psychotherapy. A covered family or conjoint psychotherapy session is no more than 90 minutes in length. A family or conjoint psychotherapy session of up to 180 minutes in length is payable for crisis intervention.

(d) Psychoanalysis. Psychoanalysis is covered when provided by a graduate or candidate of a psychoanalytic training institution recognized by the American Psychological Association or the American Psychiatric Association and when preauthorized by the Director, OCHAMPUS, or a designee.

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(e) Psychological testing and assessment. Psychological testing and assessment is generally limited to six hours of testing in a fiscal year when medically or psychologically necessary and in conjunction with otherwise covered psychotherapy. Testing or assessment in excess of these limits requires review for medical necessity. Benefits will not be provided for the Reitan-Indiana battery when administered to a patient under age five, for self-administered tests administered to patients under age 13, or for psychological testing and assessment as part of an assessment for academic placement.

(f) Administration of psychotropic drugs. When prescribed by an authorized provider qualified by licensure to prescribe drugs.

(g) Electroconvulsive treatment. When provided in accordance with guidelines issued by the Director, OCHAMPUS.

(h) Collateral visits. Covered collateral visits are those that are medically or psychologically necessary for the treatment of the patient and, as such, are considered as a psychotherapy session for purposes of subparagraph C.3.i.(2) of this chapter.

(2) Limitations and review requirements

(a) Outpatient psychotherapy. Outpatient psychotherapy generally is limited to a maximum of two psychotherapy sessions per week, in any combination of individual, family, conjoint, collateral, or group sessions. Before benefits can be extended for more than two outpatient psychotherapy sessions per week, professional review of the medical or psychological necessity for and appropriateness of the more intensive therapy is required.

(b) Inpatient psychotherapy. Coverage of inpatient psychotherapy is based on the medical or psychological necessity for the services identified in the patient's treatment plan. As a general rule, up to five psychotherapy sessions per week are considered appropriate. Additional sessions per week or more than one type of psychotherapy session performed on the same day (for example, an individual psychotherapy session and a family psychotherapy session on the same day) could be considered for coverage, depending on the medical or psychological necessity for the services. Benefits for inpatient psychotherapy will end automatically when authorization has been granted for the maximum number of inpatient mental health days in accordance with the limits as described in this Chapter 4, unless additional coverage is granted by the Director, OCHAMPUS or a designee.

(3) Covered ancillary therapies. Includes art, music, dance, occupational, and other ancillary therapies, when included by the attending provider in an approved inpatient, residential treatment plan and under the clinical supervision of a licensed doctoral level mental health professional. These ancillary therapies are not separately reimbursed professional services but are included within the institutional reimbursement.

(4) Review of claims for treatment of mental disorder. The Director, OCHAMPUS, shall establish and maintain procedures for review, including professional review, of the services provided for the treatment of mental disorders.

j. Physical and occupational therapy

(1) Physical therapy. To be covered, physical therapy must be related to a covered medical condition. If performed by other than a physician, a physician (or other authorized individual professional provider acting within the scope of their license) shall refer the patient for treatment and supervise the physical therapy. Generally, coverage of outpatient physical therapy is limited to a 60-day period, at up to two physical therapy sessions per week. Physical therapy beyond this length or frequency requires documentation of the medical necessity for the therapy and the anticipated results of the therapy. General exercise programs are not covered, even if recommended by a physician and conducted by qualified personnel. Passive exercises and range of motion exercises are not covered except when prescribed as an integral part of a comprehensive program of physical therapy.

(2) Occupational therapy. To be covered, occupational therapy must be related to a covered medical condition and must be directed to assisting the patient to overcome or compensate for disability resulting from illness, injury, or the effects of treatment of a covered condition. If performed by other than a physician, a physician shall prescribe the treatment and a physician shall supervise the occupational therapy. The occupational therapist providing the therapy shall be an employee of a CHAMPUS-authorized institutional provider and the services must be rendered in connection with CHAMPUS authorized care. Only those occupational therapy services that are rendered as part of an organized inpatient or outpatient rehabilitation program are covered. Occupational therapists are not considered CHAMPUS-authorized providers in their own right and may not submit bills on a fee-for-service basis. The employing institutional provider shall bill for the services of the occupational therapist.

k. Well-baby care. Benefits routinely are payable for well-baby care from birth up to the child's second birthday.

(1) The following services are payable when rendered as a part of a specific well-baby care program and when rendered by the attending pediatrician, family physician, or a pediatric nurse practitioner:

- (a) Newborn examination, PKU tests, and newborn circumcision.
- (b) History, physical examination, discussion, and counseling.
- (c) Vision, hearing, and dental screening.
- (d) Developmental appraisal.
- (e) Immunization (that is, DPT, polio, measles, mumps, and rubella).
- (f) Tuberculin test, hematocrit or Hgb., and urinalysis.

(2) Additional services or visits required because of specific findings or because of the particular circumstance of the individual case are covered if medically necessary and otherwise authorized for benefits under CHAMPUS.

- d. Rh immune globulin.
- e. Genetic tests as specified in paragraph E.3.b. of this chapter.

f. Immunizations and physical examinations provided when required in the case of dependents of active duty military personnel who are traveling outside the United States as a result of an active member's duty assignment and such travel is being performed under orders issued by a Uniformed Service.

38. Chiropractors and naturopaths. Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider.

39. Counseling. Counseling services that are not medically necessary in the treatment of a diagnosed medical condition; for example, educational counseling, vocational counseling, nutritional counseling, counseling for socio-economic purposes, diabetic self-education programs, stress management, life style modification, etc. Services provided by a marriage and family, pastoral or mental health counselor in the treatment of a mental disorder are covered only as specifically provided in Chapter 6. Services provided by alcoholism rehabilitation counselors and certified addiction counselors are covered only when rendered in a CHAMPUS-authorized treatment setting and only when the cost of those services is included in the facility's CHAMPUS-determined allowable cost-rate.

40. Acupuncture. Acupuncture, whether used as a therapeutic agent or as an anesthetic.

41. Hair transplants, wigs, or hairpieces

NOTE: In accordance with Section 744 of the DoD Appropriation Act for 1981 (reference (c)), CHAMPUS coverage for wigs or hairpieces is permitted effective December 15, 1980, under the conditions listed below. Continued availability of benefits will depend on the language of the annual DoD Appropriation Acts.

a. Benefits provided. Benefits may be extended, in accordance with the CHAMPUS-determined allowable charge, for one wig or hairpiece per beneficiary (lifetime maximum) when the attending physician certifies that alopecia has resulted from treatment of a malignant disease and the beneficiary certifies that a wig or hairpiece has not been obtained previously through the U.S. Government (including the Veterans Administration).

b. Exclusions. The wig or hairpiece benefit does not include coverage for the following:

(1) Alopecia resulting from conditions other than treatment of malignant disease.

(2) Maintenance, wig or hairpiece supplies, or replacement of the wig or hairpiece.

(3) Hair transplants or any other surgical procedure involving the attachment of hair or a wig or hairpiece to the scalp.

(4) Any diagnostic or therapeutic method or supply intended to encourage hair regrowth.

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42. Education or training. Self-help, academic education or vocational training services and supplies, unless the provisions of Chapter 4, paragraph B.1.e., relating to general or special education, apply.

43. Exercise/Relaxation/Comfort Devices. Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

44. Exercise. General exercise programs, even if recommended by a physician and regardless of whether or not rendered by an authorized provider. In addition, passive exercises and range of motion exercises also are excluded, except when prescribed by a physician and rendered by a physical therapist concurrent to, and as an integral part of, a comprehensive program of physical therapy.

45. Audiologist, speech therapist. Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of treatment addressed to the physical defect itself and not to any educational or occupational deficit.

46. Vision care. Eye exercises or visual training (orthoptics).

47. Eye and hearing examinations. Eye and hearing examinations except as specifically provided in paragraph C.2.p. of this chapter or except when rendered in connection with medical or surgical treatment of a covered illness or injury. Vision and hearing screening in connection with well-baby care is not excluded.

48. Prosthetic devices. Prostheses, except artificial limbs and eyes, or if an item is inserted surgically in the body as an integral part of a surgical procedure. All dental prostheses are excluded, except for those specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

49. Orthopedic shoes. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes, or regular shoes later built up.

50. Eyeglasses. Eyeglasses, spectacles, contact lenses, or other optical devices, except as specifically provided under subsection E.6. of this chapter.

51. Hearing aids. Hearing aids or other auditory sensory enhancing devices.

52. Telephonic services. Services or advice rendered by telephone or other telephonic device, including remote monitoring, except for transtelephonic monitoring of cardiac pacemakers.

53. Air conditioners, humidifiers, dehumidifiers, and purifiers.

54. Elevators or chair lifts.

55. Alterations. Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.

56. Clothing. Items of clothing or shoes, even if required by virtue of an allergy (such as cotton fabric as against synthetic fabric and vegetable dyed shoes).

57. Food, food substitutes. Food, food substitutes, vitamins, or other nutritional supplements, including those related to prenatal care.

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53. Enuresis. Enuretic devices; enuretic conditioning programs.

59. RESERVED.

60. Autopsy and postmortem.

61. Camping. All camping even though organized for a specific therapeutic purpose (such as diabetic camp or a camp for emotionally disturbed children), and even though offered as a part of an otherwise covered treatment plan or offered through a CHAMPUS-approved facility.

62. Housekeeper, companion. Housekeeping, homemaker, or attendant services; sitter or companion.

63. Noncovered condition, unauthorized provider. All services and supplies (including inpatient institutional costs) related to a noncovered condition or treatment, or provided by an unauthorized provider.

64. Comfort or convenience. Personal, comfort, or convenience items such as beauty and barber services, radio, television, and telephone.

65. "Stop smoking" programs. Services and supplies related to "stop smoking" regimens.

66. Megavitamin psychiatric therapy, orthomolecular psychiatric therapy.

67. Transportation. All transportation except by ambulance, as specifically provided under section D. of this chapter, and except as authorized in subsection E.5. of this chapter.

68. Travel. All travel even though prescribed by a physician and even if its purpose is to obtain medical care, except as specified in subsection A.6. of this chapter in connection with a CHAMPUS-required physical examination.

69. Institutions. Services and supplies provided by other than a hospital, unless the institution has been approved specifically by OCHAMPUS. Nursing homes, intermediate care facilities, halfway houses, homes for the aged, or institutions of similar purpose are excluded from consideration as approved facilities under the Basic Program.

NOTE: In order to be approved under CHAMPUS, an institution must, in addition to meeting CHAMPUS standards, provide a level of care for which CHAMPUS benefits are payable.

70. Supplemental diagnostic services. Diagnostic services including clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results performed by civilian providers at the request of the attending Uniformed Service medical department physician (active duty or civil service).

71. Supplemental consultations. Consultations provided by civilian providers at the request of the attending Uniformed Services medical department physician (active duty or civil service).

72. Inpatient mental health services. Effective for care received on or after October 1, 1991, services in excess of 30 days in any fiscal year (or in an admission), in the case of a patient nineteen years of age or older, 45 days in

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any fiscal year (or in an admission) in the case of a patient under 19 years of age, or 150 days in any fiscal year (or in an admission) in the case of inpatient mental health services provided as residential treatment care, unless coverage for such services is granted by a waiver by the Director, OCHAMPUS, or a designee. In cases involving the day limitations, waivers shall be handled in accordance with paragraphs B.8. or B.9. of this chapter. For services prior to October 1, 1991, services in excess of 60 days in any calendar year unless additional coverage is granted by the Director, OCHAMPUS, or a designee.

73. Economic interest in connection with mental health admissions. Inpatient mental health services (including both acute care and RTC services) are excluded for care received when a patient is referred to a provider of such services by a physician (or other health care professional with authority to admit) who has an economic interest in the facility to which the patient is referred, unless a waiver is granted. Requests for waiver shall be considered under the same procedure and based on the same criteria as used for obtaining preadmission authorization (or continued stay authorization for emergency admissions), with the only additional requirement being that the economic interest be disclosed as part of the request. The same reconsideration and appeals procedures that apply to day limit waivers shall also apply to decisions regarding requested waivers of the economic interest exclusion. However, a provider may appeal a reconsidered determination that an economic relationship constitutes an economic interest within the scope of the exclusion to the same extent that a provider may appeal determinations under paragraph I.3., Chapter 15. This exclusion does not apply to services under the Program for the Handicapped (Chapter 5 of this Regulation) or provided as partial hospital care. If a situation arises where a decision is made to exclude CHAMPUS payment solely on the basis of the provider's economic interest, the normal CHAMPUS appeals process will be available.

74. Not specifically listed. Services and supplies not specifically listed as a benefit in this Regulation. This exclusion is not intended to preclude extending benefits for those services or supplies specifically determined to be covered within the intent of this Regulation by the Director, OCHAMPUS, or a designee, even though not otherwise listed.

NOTE: The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not listed specifically as an exclusion.

H. Payment and liability for certain potentially excludable services under the Peer Review Organization program.

1. Applicability. This section provides special rules that apply only to services retrospectively determined under the Peer Review Organization (PRO) program (operated pursuant to Chapter 15) to be potentially excludable (in whole or in part) from the Basic Program under section G. of this chapter. Services may be excluded by reason of being not medically necessary (subsection G.1.) at an inappropriate level (subsection G.3.) custodial care (subsection G.7.) or other reason relative to reasonableness, necessity or appropriateness (which services shall throughout the remainder of this section, be referred to as "not medically necessary"). (Also throughout the remainder of the section, "services" includes items and "provider" includes supplier.) This section does not apply to coverage determinations made by OCHAMPUS or the fiscal intermediaries which are not based on medical necessity determinations made under the PRO program.

2. Payment for certain potentially excludable expenses. Services determined under the PRO program to be potentially excludable by reason of the exclusions in

section G. of this chapter for not medically necessary services will not be determined to be excludable if neither the beneficiary to whom the services were provided nor the provider (institutional or individual) who furnished the services knew, or could reasonably have been expected to know, that the services were subject to those exclusions. Payment may be made for such services as if the exclusions did not apply.

3. Liability for certain excludable services. In any case in which items or services are determined excludable by the PRO program by reason of being not medically necessary and payment may not be made under subsection H.2., above because the requirements of subsection H.2. are not met, the beneficiary may not be held liable (and shall be entitled to a full refund from the provider of the amount excluded and any cost-share amount already paid) if:

a. The beneficiary did not know and could not reasonably have been expected to know that the services were excludable by reason of being not medically necessary; and

b. The provider knew or could reasonably have been expected to know that the items or services were excludable by reason of being not medically necessary.

4. Criteria for determining that beneficiary knew or could reasonably have been expected to have known that services were excludable. A beneficiary who receives services excludable by reason of being not medically necessary will be found to have known that the services were excludable if the beneficiary has been given written notice that the services were excludable or that similar or comparable services provided on a previous occasion were excludable and that notice was given by the OCHAMPUS, CHAMPUS PRO or fiscal intermediary, a group or committee responsible for utilization review for the provider, or the provider who provided the services.

5. Criteria for determining that provider knew or could reasonably have been expected to have known that services were excludable. An institutional or individual provider will be found to have known or been reasonably expected to have known that services were excludable under this section under any one of the following circumstances:

a. The PRO or fiscal intermediary had informed the provider that the services provided were excludable or that similar or reasonably comparable services were excludable.

b. The utilization review group or committee for an institutional provider or the beneficiary's attending physician had informed the provider that the services provided were excludable.

c. The provider had informed the beneficiary that the services were excludable.

d. The provider had received written materials, including notices, manual issuance, bulletins, guides, directives, or other materials, providing notification of PRO screening criteria specific to the condition of the beneficiary. Attending physicians who are members of the medical staff

of an institutional provider will be found to have also received written materials provided to the institutional provider.

e. The services that are at issue are the subject of what are generally considered acceptable standards of practice by the local medical community.

f. Preadmission authorization was available but not requested, or concurrent review requirements were not followed.

CHAPTER 6

AUTHORIZED PROVIDERS

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6. Exclusion of beneficiary liability. In connection with certain utilization review, quality assurance and preauthorization requirements of Chapter 4, providers may not hold patients liable for payment for certain services for which CHAMPUS payment is disallowed. With respect to such services, providers may not seek payment from the patient or the patient's family. Any such effort to seek payment is a basis for termination of the provider's authorized status.

7. Provider required. In order to be considered for benefits, all services and supplies shall be rendered by, prescribed by, or furnished at the direction of, or on the order of a CHAMPUS-authorized provider practicing within the scope of his or her license.

8. Participating provider. Under CHAMPUS, authorized professional providers and institutional providers other than hospitals have the option of participating on a claim-by-claim basis. Participation is required for inpatient claims only for hospitals which are Medicare-participating providers. Hospitals which are not Medicare-participating providers but which are subject to the CHAMPUS DRG-based payment system in subsection A.1. of Chapter 14 or the CHAMPUS mental health per diem payment system in subsection A.2. of Chapter 14 must sign agreements to participate on all CHAMPUS inpatient claims in order to be authorized providers under CHAMPUS. All other hospitals may elect to participate on a claim-by-claim basis. Participating providers must indicate participation by signing the appropriate space on the applicable CHAMPUS claim form and submitting it to the appropriate CHAMPUS fiscal intermediary on behalf of the beneficiary. In the case of an institution or medical supplier, the claim must be signed by an official having such authority. This certifies that the provider has agreed to accept the CHAMPUS-determined allowable charge or cost as payment in full for the medical services and supplies listed on the specific claim form; and has agreed to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing and deductible amounts paid by, or on behalf of, the beneficiary as full payment for the covered medical services and supplies.

9. Limitation to authorized institutional provider designation. Authorized institutional provider status granted to a specific institutional provider applicant does not extend to any institution-affiliated provider, as defined in Chapter 2 of this Regulation, of that specific applicant.

10. Authorized provider. A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized in this chapter to provide benefits under CHAMPUS. In addition, to be an authorized CHAMPUS provider, any hospital which is a CHAMPUS participating provider under Section A.7. of this chapter, shall be a participating provider for all care, services, or supplies furnished to an active duty member of the uniformed services for which the active duty member is entitled under title 10, United States Code, section 1074(c). As a participating provider for active duty members, the CHAMPUS authorized hospital shall provide such care, services, and supplies in accordance with the payment rules of Chapter 16. The failure of any CHAMPUS participating hospital to be a participating provider for any active duty member subjects the hospital to termination of the hospital's status as a CHAMPUS authorized provider for failure to meet the qualifications established by this chapter.

B. INSTITUTIONAL PROVIDERS

1. General. Institutional providers are those providers who bill for services in the name of an organizational entity (such as hospital and skilled

nursing facility), rather than in the name of a person. The term "institutional provider" does not include professional corporations or associations qualifying as a domestic corporation under section 301.7701-5 of the Internal Revenue Service Regulations (reference (cc)), nor does it include other corporations that provide principally professional services. Institutional providers may provide medical services and supplies on either an inpatient or outpatient basis.

a. Preauthorization. The Director, OCHAMPUS, reserves the right to require preauthorization for admission to inpatient facilities. Refer to Chapter 4, subsection A.11., for information on preauthorization.

b. Billing practices.

(1) Each institutional billing, including those institutions subject to the CHAMPUS DRG-based reimbursement method or a CHAMPUS-determined all-inclusive rate reimbursement method, must be itemized fully and sufficiently descriptive for the CHAMPUS to make a determination of benefits.

(2) Institutional claims subject to the CHAMPUS DRG-based reimbursement method or a CHAMPUS-determined all-inclusive rate reimbursement method, may be submitted only after the beneficiary has been discharged or transferred from the institutional provider's facility or program.

(3) Institutional claims for Residential Treatment Centers and all other institutional providers, except those listed in subparagraph (2) above, should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days.

2. Nondiscrimination policy. Except as provided below, payment may not be made for inpatient or outpatient care provided and billed by an institutional provider found by the Federal Government to practice discrimination in the admission of patients to its services on the basis of race, color, or national origin. Reimbursement may not be made to a beneficiary who pays for care provided by such a facility and submits a claim for reimbursement. In the following circumstances, the Secretary of Defense, or a designee, may authorize payment for care obtained in an ineligible facility:

a. Emergency care. Emergency inpatient or outpatient care.

b. Care rendered before finding of a violation. Care initiated before a finding of a violation and which continues after such violation when it is determined that a change in the treatment facility would be detrimental to the health of the patient, and the attending physician so certifies.

c. Other facility not available. Care provided in an ineligible facility because an eligible facility is not available within a reasonable distance.

3. Procedures for qualifying as a CHAMPUS-approved institutional provider. General and special hospitals otherwise meeting the qualifications outlined in paragraphs B.4.a., b., and c., of this chapter are not required to request CHAMPUS approval formally.

6 Declare an STF not eligible for CHAMPUS payment if that facility has been found to have engaged in fraudulent or deceptive practices.

(c) In general, the following disclaimers apply to treatment by STFs:

1 Just because one period or episode of treatment by a facility has been covered by CHAMPUS may not be construed to mean that later episodes of care by the same or similar facility will be covered automatically.

2 The fact that one case has been authorized for treatment by a specific facility or similar type of facility may not be construed to mean that similar cases or later periods of treatment will be extended CHAMPUS benefits automatically.

(2) Types of providers. The following is a list of facilities that have been designated specifically as STFs.

(a) Free-standing ambulatory surgical centers. Care provided by freestanding ambulatory surgical centers may be cost-shared by CHAMPUS under the following circumstances:

1 The treatment is prescribed and supervised by a physician.

2 The type and level of care and services rendered by the center are otherwise authorized by this Regulation.

3 The center meets all licensing or other certification requirements of the jurisdiction in which the facility is located.

4 The center is accredited by the JCAHO, the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), or such other standards as authorized by the Director, OCHAMPUS.

5 A childbirth procedure provided by a CHAMPUS-approved free-standing ambulatory surgical center shall not be cost-shared by CHAMPUS unless the surgical center is also a CHAMPUS-approved birthing center institutional provider as established by the birthing center provider certification requirement of this Regulation.

(b) PFTH facilities. STFs also include facilities that seek approval to provide care authorized under the PFTH. (Refer to Chapter 5 of this Regulation.)

(c) Substance use disorder rehabilitation facilities. In order to be authorized under CHAMPUS as a provider of substance use detoxification, rehabilitative services, outpatient treatment, and family therapy, substance use rehabilitation facilities, both freestanding facilities and hospital-based facilities, shall operate primarily for the purpose of providing treatment of substance use disorders (on either an inpatient (including partial care) or an outpatient basis) and shall meet the following criteria:

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1 The course of treatment shall be prescribed by and supervised by a qualified mental health provider (refer to Chapter 4, paragraph C.3.i.) practicing within the scope of his or her license. When indicated by the patient's physical status, the patient shall be under the general supervision of a physician.

2 The type and level of care provided by the facility are otherwise authorized by this Regulation.

3 The facility shall meet all licensing and other certification requirements of the jurisdiction in which the facility is located.

4 The facility shall be accredited by and shall remain in substantial compliance with standards issued by either the Joint Commission on Accreditation of Healthcare Organizations under the Consolidated Standards Manual, or the Commission Accreditation of Rehabilitation Facilities (CARF) or shall meet such other requirements as the Director, OCHAMPUS, finds necessary in the interest of the health and safety of the individuals who are furnished services in the facility.

5 The facility shall have entered into a participation agreement with OCHAMPUS within which the facility agrees, in part, to:

a Accept payment for its services based on an allowable-cost rate acceptable to the Director, OCHAMPUS, or such other method as determined by the Director, OCHAMPUS;

b Furnish OCHAMPUS with cost data certified to by an independent accounting firm or other agency as authorized by the Director, OCHAMPUS;

c Accept the CHAMPUS-determined rate as payment in full and to collect from the CHAMPUS beneficiary those amounts that represent the beneficiary's liability, as defined in Chapter 4, and charges for services and supplies that are not a benefit of CHAMPUS;

d Make all reasonable efforts acceptable to the Director, OCHAMPUS, to collect those amounts which represent the beneficiary's liability, as defined in Chapter 4;

e Permit access by the Director, OCHAMPUS, to clinical records of CHAMPUS beneficiaries and to the financial and organizational records of the facility;

f Comply with the provisions of Chapter 8, and to submit claims first to all health insurance coverage to which the beneficiary is entitled that is primary to CHAMPUS.

6 The substance use rehabilitation facility shall not be considered to be a CHAMPUS-authorized provider and CHAMPUS benefits shall not be paid for services provided by the substance use rehabilitation facility until the date the participation agreement is signed by the Director, OCHAMPUS, or a designee.

7 The substance use rehabilitation facility is not designated by the Health Care Financing Administration as an alcohol and drug abuse hospital for purposes of applicability of the Medicare prospective payment system.

k. Birthing centers. A birthing center is a freestanding or institution-affiliated outpatient maternity care program which principally provides a planned course of outpatient prenatal care and outpatient childbirth service limited to low-risk pregnancies; excludes care for high-risk pregnancies; limits childbirth to the use of natural childbirth procedures; and provides immediate newborn care.

(1) Certification requirements. A birthing center which meets the following criteria may be designated as an authorized CHAMPUS institutional provider:

(a) The predominant type of service and level of care rendered by the center is otherwise authorized by this Regulation.

(b) The center is licensed to operate as a birthing center where such license is available, or is specifically licensed as a type of ambulatory health care facility where birthing center specific license is not available, and meets all applicable licensing or certification requirements that are extant in the state, county, municipality, or other political jurisdiction in which the center is located.

(c) The center is accredited by a nationally recognized accreditation organization whose standards and procedures have been determined to be acceptable by the Director, OCHAMPUS, or a designee.

(d) The center complies with the CHAMPUS birthing center standards set forth in this Chapter.

(e) The center has entered into a participation agreement with OCHAMPUS in which the center agrees, in part, to:

1 Participate in CHAMPUS and accept payment for maternity services based upon the reimbursement methodology for birthing centers;

2 Collect from the CHAMPUS beneficiary only those amounts that represent the beneficiary's liability under the participation agreement and the reimbursement methodology for birthing centers, and the amounts for services and supplies that are not a benefit of the CHAMPUS;

3 Permit access by the Director, OCHAMPUS, or a designee, to the clinical record of any CHAMPUS beneficiary, to the

financial and organizational records of the center, and to reports of evaluations and inspections conducted by state or private agencies or organizations;

4 Submit claims first to all health benefit and insurance plans primary the CHAMPUS to which the beneficiary is entitled and to comply with the double coverage provisions of this Regulation.

5 Notify OCHAMPUS in writing within 7 days of the emergency transport of any CHAMPUS beneficiary from the center to an acute care hospital or of the death of any CHAMPUS beneficiary in the center.

(f) A birthing center shall not be a CHAMPUS-authorized institutional provider and CHAMPUS benefits shall not be paid for any service provided by a birthing center before the date the participation agreement is signed by the Director, OCHAMPUS, or a designee.

(2) CHAMPUS birthing center standards.

(a) Environment. The center has a safe and sanitary environment, properly constructed, equipped, and maintained to protect health and safety and meets the applicable provisions of the "Life Safety Code" of the National Fire Protection Association.

(b) Policies and procedures. The center has written administrative, fiscal, personnel and clinical policies and procedures which collectively promote the provision of high-quality maternity care and childbirth services in an orderly, effective, and safe physical and organizational environment.

(c) Informed consent. Each CHAMPUS beneficiary admitted to the center will be informed in writing at the time of admission of the nature and scope of the center's program and of the possible risks associated with maternity care and childbirth in the center.

(d) Beneficiary care. Each woman admitted will be cared for by or under the direct supervision of a specific physician or a specific certified nurse-midwife who is otherwise eligible as a CHAMPUS individual professional provider.

(e) Medical direction. The center has written memoranda of understanding (MOU) for routine consultation and emergency care with an obstetrician-gynecologist who is certified or is eligible for certification by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology and with a pediatrician who is certified or eligible for certification by the American Board of Pediatrics or by the American Osteopathic Board of Pediatrics, each of whom have admitting privileges to at least one back-up hospital. In lieu of a required MOU, the center may employ a physician with the required qualifications. Each MOU must be renewed annually.

CHAPTER 14

PROVIDER REIMBURSEMENT METHODS

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b From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of another hospital paid under this system;

c From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of another hospital that is excluded from the CHAMPUS DRG-based payment system because of participation in a statewide cost control program which is exempt from the CHAMPUS DRG-based payment system under subparagraph A.1.b.(1) of this chapter; or

d From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of a uniformed services treatment facility.

3 Payment in full to the discharging hospital. The hospital discharging an inpatient shall be paid in full under the CHAMPUS DRG-based payment system.

4 Payment to a hospital transferring an inpatient to another hospital. If a hospital subject to the CHAMPUS DRG-based payment system transfers an inpatient to another such hospital, the transferring hospital shall be paid a per diem rate (except that in neonatal cases, other than normal newborns, the hospital will be paid at 125 percent of that per diem rate), as determined under instructions issued by OCHAMPUS, for each day of the patient's stay in that hospital, not to exceed the DRG-based payment that would have been paid if the patient had been discharged to another setting. However, if a discharge is classified into DRG No. 456 (Burns, transferred to another acute care facility) or DRG 601 (neonate, transferred less than or equal to 4 days old), the transferring hospital shall be paid in full.

5 Additional payments to transferring hospitals. A transferring hospital may qualify for an additional payment for extraordinary cases that meet the criteria for long-stay or cost outliers.

(4) DRG system updates. The CHAMPUS DRG-based payment system is modeled on the Medicare Prospective Payment System (PPS) and uses annually updated items and numbers from the Medicare PPS as provided for in this Part and in instructions issued by the Director, OCHAMPUS. The effective date of these items and numbers shall correspond to that under the Medicare PPS except where distinctions are made in this chapter.

b. Applicability of the DRG system.

(1) Areas affected. The CHAMPUS DRG-based payment system shall apply to hospitals' services in the fifty states, the District of Columbia, and Puerto Rico, except that any state which has implemented a separate DRG-based payment system or similar payment system in order to control costs and is exempt from the Medicare Prospective Payment System may be exempt from the CHAMPUS DRG-based payment system if it requests exemption in writing, and provided payment under such system does not exceed payment which would otherwise be made under the CHAMPUS DRG-based payment system.

(2) Services subject to the DRG-based payment system. All normally covered inpatient hospital services furnished to CHAMPUS beneficiaries by hospitals are subject to the CHAMPUS DRG-based payment system.

(3) Services exempt from the DRG-based payment system. The following hospital services, even when provided in a hospital subject to the CHAMPUS DRG-based payment system, are exempt from the CHAMPUS DRG-based payment system. The services in subparagraphs A.1.b.(3)(a) through (d) and (g) through (i) shall be reimbursed under the procedures in subsection A.3. of this chapter, and the services in subparagraphs A.1.b.(3)(e) and (f) shall be reimbursed under the procedures in section G. of this chapter.

(a) Services provided by hospitals exempt from the DRG-based payment system.

(b) All services related to kidney acquisition by Renal Transplantation Centers.

(c) All services related to a heart transplantation which would otherwise be paid under DRG 103.

(d) All services related to liver transplantation when the transplant is performed in a CHAMPUS-authorized liver transplantation center.

(e) All professional services provided by hospital-based physicians.

(f) All services provided by nurse anesthetists.

(g) All services related to discharges involving pediatric bone marrow transplants (patient under 18 at admission).

(h) All services related to discharges involving children who have been determined to be HIV seropositive (patient under 18 at admission).

(i) All services related to discharges involving pediatric cystic fibrosis (patient under 18 at admission).

(j) For admissions occurring on or after October 1, 1990, the costs of blood clotting factor for hemophilia inpatients. An additional payment shall be made to a hospital for each unit of blood clotting factor furnished to a CHAMPUS inpatient who is hemophiliac in accordance with the amounts established under the Medicare Prospective Payment System (42 CFR 412.115).

(4) Hospitals subject to the CHAMPUS DRG-based payment system. All hospitals within the fifty states, the District of Columbia, and Puerto Rico which are certified to provide services to CHAMPUS beneficiaries are subject to the DRG-based payment system except for the following hospitals or hospital units which are exempt.

(a) Psychiatric hospitals. A psychiatric hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS DRG-based payment system. In order for a psychiatric hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in Section 412.23 of Title 42 CFR.

(b) Rehabilitation hospitals. A rehabilitation hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS DRG-based payment system. In order for a rehabilitation hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in Section 412.23 of Title 42 CFR.

(c) Psychiatric and rehabilitation units (distinct parts). A psychiatric or rehabilitation unit which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a distinct unit which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in Section 412.23 of Title 42 CFR.

(d) Long-term hospitals. A long-term hospital which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a long-term hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must have an average length of inpatient stay greater than 25 days:

1 As computed by dividing the number of total inpatient days (less leave or pass days) by the total number of discharges for the hospital's most recent fiscal year; or

2 As computed by the same method for the immediately preceding six-month period, if a change in the hospital's average length of stay is indicated.

(e) Sole community hospitals. Any hospital which has qualified for special treatment under the Medicare prospective payment system as a sole community hospital and has not given up that classification is exempt from the CHAMPUS DRG-based payment system. (See Subpart G of 42 CFR Part 412.)

(f) Christian Science sanitoriums. All Christian Science sanitoriums (as defined in paragraph B.4.h. of Chapter 6) are exempt from the CHAMPUS DRG-based payment system.

(g) Cancer hospitals. Any hospital which qualifies as a cancer hospital under the Medicare standards and has elected to be exempt from the Medicare prospective payment system is exempt from the CHAMPUS DRG-based payment system. (See 42 CFR Section 412.94.)

(h) Hospitals outside the 50 states, the District of Columbia, and Puerto Rico. A hospital is excluded from the CHAMPUS DRG-based payment system if it is not located in one of the fifty States, the District of Columbia, or Puerto Rico.

(5) Hospitals which do not participate in Medicare. It is not required that a hospital be a Medicare-participating provider in order to be an authorized CHAMPUS provider. However, any hospital which is subject to the CHAMPUS DRG-based payment system and which otherwise meets CHAMPUS requirements but which is not a Medicare-participating provider (having completed a form HCFA-1514, Hospital Request for Certification in the Medicare/Medicaid Program and a form HCFA-1561, Health Insurance Benefit Agreement) must complete a participation agreement with OCHAMPUS. By completing the participation agreement, the hospital agrees to participate on all CHAMPUS inpatient claims and to accept the CHAMPUS-determined allowable amount as payment in full for these claims. Any hospital which does not participate in Medicare and does not complete a participation agreement with OCHAMPUS will not be authorized to provide services to CHAMPUS beneficiaries.

c. Determination of payment amounts. The actual payment for an individual claim under the CHAMPUS DRG-based payment system is calculated by multiplying the appropriate adjusted standardized amount (adjusted to account for area wage differences using the wage indexes used in the Medicare program) by a weighting factor specific to each DRG.

(1) Calculation of DRG Weights.

(a) Grouping of charges. All discharge records in the database shall be grouped by DRG.

(b) Remove DRGs 469 and 470. Records from DRGs 469 and 470 shall be removed from the database.

(c) Indirect medical education standardization. To standardize the charges for the cost effects of indirect medical education factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.43 \times \left[\left(1.0 + \frac{\text{number of interns} + \text{residents}}{\text{number of beds}} \right)^{.5795} - 1.0 \right]$$

(d) Wage level standardization. To standardize the charge records for area wage differences, each charge record will be divided into labor-related and nonlabor-related portions, and the labor-related portion shall be divided by the most recently available Medicare wage index for the area. The labor-related and nonlabor-related portions will then be added together.

(e) Elimination of statistical outliers. All unusually high or low charges shall be removed from the database.

(f) Calculation of DRG average charge. After the standardization for indirect medical education, and area wage differences, an average charge for each DRG shall be computed by summing charges in a DRG and dividing that sum by the number of records in the DRG.

(g) Calculation of national average charge per discharge. A national average charge per discharge shall be calculated by summing all charges and dividing that sum by the total number of records from all DRG categories.

(h) DRG relative weights. DRG relative weights shall be calculated for each DRG category by dividing each DRG average charge by the national average charge.

(2) Empty and low-volume DRGs. The Medicare weight shall be used for any DRG with less than ten (10) occurrences in the CHAMPUS database. The short-stay thresholds shall be set at one day for these DRGs and the long-stay thresholds shall be set at the FY 87 Medicare thresholds.

(3) Updating DRG weights. The CHAMPUS DRG weights shall be updated or adjusted as follows:

(a) DRG weights shall be recalculated annually using CHAMPUS charge data and the methodology described in subparagraph A.1.c.(1) of this chapter.

(b) When a new DRG is created, CHAMPUS will, if practical, calculate a weight for it using an appropriate charge sample (if available) and the methodology described in subparagraph A.1.c.(1) of this chapter.

(c) In the case of any other change under Medicare to an existing DRG weight (such as in connection with technology changes), CHAMPUS shall adjust its weight for that DRG in a manner comparable to the change made by Medicare.

(4) Calculation of the adjusted standardized amounts. The following procedures shall be followed in calculating the CHAMPUS adjusted standardized amounts.

(a) Differentiate large urban, other urban, and rural charges. All charges in the database shall be sorted into large urban, other urban, and rural groups (using the same definitions for these categories used in the Medicare program). The following procedures will be applied to each group.

(b) Indirect medical education standardization. To standardize the charges for the cost effects of indirect medical education factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.43 \times \left[\left\{ 1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right\}^{.5795} - 1.0 \right]$$

(c) Wage level standardization. To standardize the charge records for area wage differences, each charge record will be divided into labor-related and nonlabor-related portions, and the labor-related portion shall be divided by the most recently available Medicare wage index for the area. The labor-related and nonlabor-related portions will then be added together.

(d) Apply the cost to charge ratio. Each charge is to be reduced to a representative cost by using the Medicare cost to charge ratio. This amount shall be increased by 1 percentage point in order to reimburse hospitals for bad debt expenses attributable to CHAMPUS beneficiaries.

(e) Preliminary base year standardized amount. A preliminary base year standardized amount shall be calculated by summing all costs in the database applicable to the large urban, other urban, or rural group and dividing by the total number of discharges in the respective group.

(f) Update for inflation. The preliminary base year standardized amounts shall be updated using an annual update factor equal to 1.07 to produce fiscal year 1988 preliminary standardized amounts. Thereafter, any development of a new standardized amount will use an inflation factor equal to the hospital market basket index used by the Health Care Financing Administration in their Prospective Payment System.

(g) The preliminary standardized amounts, updated for inflation, shall be divided by a system standardization factor so that total DRG outlays, given the database distribution across hospitals and diagnoses, are equal to the total charges reduced to costs.

(h) Labor and nonlabor portions of the adjusted standardized amounts. The adjusted standardized amounts shall be divided into labor and nonlabor portions in accordance with the Medicare division of labor and nonlabor portions.

(5) Adjustments to the DRG-based payment amounts. The following adjustments to the DRG-based amounts (the weight multiplied by the adjusted standardized amount) will be made.

(a) Outliers. The DRG-based payment to a hospital shall be adjusted for atypical cases. These outliers are those cases that have either an unusually short length-of-stay or extremely long length-of-stay or that involve extraordinarily high costs when compared to most discharges classified in the same DRG. Cases which qualify as both a length-of-stay outlier and a cost outlier shall be paid at the rate which results in the greater payment.

1 Length-of-stay outliers. Length-of-stay outliers shall be identified and paid by the fiscal intermediary when the claims are processed.

a Short-stay outliers. Any discharge with a length-of-stay (LOS) less than 1.94 standard deviations from the DRG's geometric LOS shall be classified as a short-stay outlier. Short-stay outliers shall be reimbursed at 200 percent of the per diem rate for the DRG for each covered day of the hospital stay, not to exceed the DRG amount. The per diem rate shall equal the DRG amount divided by the geometric mean length-of-stay for the DRG.

b Long-stay outliers. Any discharge (except for neonatal services and services in children's hospitals) which has a length-of-stay (LOS) exceeding a threshold established in accordance with the criteria used for the Medicare Prospective Payment System as contained in 42 CFR 412.82 shall be classified as a long-stay outlier. Any discharge for neonatal services or for services in a children's hospital which has a LOS exceeding the lesser of 1.94 standard deviations or 17 days from the DRG's geometric mean LOS also shall be classified as a long-stay outlier. Long-stay outliers shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of the per diem rate for the DRG for each covered day of care beyond the long-stay outlier threshold. The per diem rate shall equal the DRG amount divided by the geometric mean LOS for the DRG.

2 Cost outliers. Additional payment for cost outliers shall be made only upon request by the hospital.

a Cost outliers except those in children's hospitals or for neonatal services. Any discharge which has standardized costs that exceed a threshold established in accordance with the criteria used for the Medicare Prospective Payment System as contained in 42 CFR 412.84 shall qualify as a cost outlier. The standardized costs shall be calculated by multiplying the total charges by the factor described in subparagraph A.1.c.(4)(d) and adjusting this amount for indirect medical education costs. Cost outliers shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold.

b Cost outliers in children's hospitals and for neonatal services. Any discharge for services in a children's hospital or for neonatal services which has standardized costs that exceed a threshold of the greater of two times the DRG-based amount or \$13,500 shall qualify as a cost outlier. The standardized costs shall be calculated by multiplying the total charges by the factor described in subparagraph A.1.c.(4)(d) (adjusted to include average capital and direct medical education costs) and adjusting this amount for indirect medical education costs. Cost outliers for services in children's hospitals and for neonatal services shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold.

c Cost outliers for burn cases. All cost outliers for DRGs related to burn cases shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold. The standardized costs and thresholds for these cases shall be calculated in accordance with subparagraph A.1.c.(5)(a) 2 a and subparagraph A.1.c.(5)(a) 2 b.

(b) Wage Adjustment. CHAMPUS will adjust the labor portion of the standardized amounts according to the hospital's area wage index.

(c) Indirect Medical Education Adjustment. The wage adjusted DRG payment will also be multiplied by 1.0 plus the hospital's indirect medical education ratio.

(d) Children's Hospital Differential. With respect to claims from children's hospitals, the appropriate adjusted standardized amount shall also be adjusted by a children's hospital differential.

1 Qualifying children's hospitals. Hospitals qualifying for the children's hospital differential are hospitals that are exempt from the Medicare Prospective Payment System, or, in the case of hospitals that do not participate in Medicare, that meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in 42 CFR 412.23.

2 Calculation of differential. The differential shall be equal to the difference between a specially calculated children's hospital adjusted standardized amount and the adjusted standardized amount for fiscal year 1988. The specially calculated children's hospital adjusted standardized amount shall be calculated in the same manner as set forth in subparagraph A.1.c.(4), except that:

a The base period shall be fiscal year 1988 and shall represent total estimated charges for discharges that occurred during fiscal year 1988.

b No cost to charge ratio shall be applied.

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c Capital costs and direct medical education costs will be included in the calculation.

d The factor used to update the database for inflation to produce the fiscal year 1988 base period amount shall be the applicable Medicare inpatient hospital market basket rate.

3 Transition rule. Until March 1, 1992, separate differentials shall be used for each higher volume children's hospital (individually) and for all other children's hospitals (in the aggregate). For this purpose, a higher volume hospital is a hospital that had 50 or more CHAMPUS discharges in fiscal year 1988.

4 Hold harmless provision. At such time as the weights initially assigned to neonatal DRGs are recalibrated based on sufficient volume of CHAMPUS claims records, children's hospital differentials shall be recalculated and appropriate retrospective and prospective adjustments shall be made. To the extent practicable, the recalculation shall also include reestimated values of other factors (including but not limited to direct education and capital costs and indirect education factors) for which more accurate data became available.

5 No update for inflation. The children's hospital differential, calculated (and later recalculated under the hold harmless provision) for the base period of fiscal year 1988, shall not be updated for subsequent fiscal years.

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**G. REIMBURSEMENT OF INDIVIDUAL HEALTH-CARE PROFESSIONALS AND OTHER
NON-INSTITUTIONAL HEALTH-CARE PROVIDERS**

The CHAMPUS-determined reasonable charge (the amount allowed by CHAMPUS) for the service of an individual health-care professional or other non-institutional health-care provider (even if employed by or under contract to an institutional provider) shall be determined by one of the following methodologies, that is, whichever is in effect in the specific geographic location at the time covered services and supplies are provided to a CHAMPUS beneficiary.

1. Allowable charge method.

a. In general. The allowable charge method is the preferred and primary method for reimbursement of individual health care professionals and other non-institutional health care providers (covered by 10 U.S.C. 1079(h)(1)). The allowable charge for authorized care shall be the lowest of the billed charge, the prevailing charge level or the appropriate charge level.

b. Prevailing charge level.

(1) Beginning in calendar year 1992, the prevailing charge level shall be calculated on a national basis, then adjusted for localities in accordance with paragraph G.1.d. of this section.

(2) The national prevailing charge level referred to in paragraph G.1.b.(1) of this section is the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period. The 80th percentile of charges shall be determined on the basis of statistical data and methodology acceptable to the Director, OCHAMPUS (or a designee).

(3) For purposes of paragraph G.1.b.(2) of this section, the base period shall be a period of 12 calendar months and shall be adjusted once a year, unless the Director, OCHAMPUS, determines that a different period for adjustment is appropriate and publishes a notice to that effect in the Federal Register.

c. Appropriate charge level. Beginning in calendar year 1992, the appropriate charge level shall be calculated on a national basis, then adjusted for localities in accordance with paragraph G.1.d. of this section. The appropriate charge level for each procedure is the product of the following two-step process:

(1) Step 1: procedures classified. All procedures are classified into one of three categories, as follows:

(a) Overpriced procedures. These are the procedures for which the prior year's national appropriate charge level or national prevailing charge level, whichever is less, exceeds the Medicare converted relative value unit (CRVU) by greater than 150 percent. For purposes of the

preceding sentence the CRVU is the Medicare Resource-Based Relative Value Scale relative value unit, converted to a dollar value by using the applicable Medicare conversion factor. For any particular procedure for which comparable CRVU and CHAMPUS data are unavailable, but alternative data are available that the Director, OCHAMPUS (or designee) determines provide a reasonable approximation of relative value or price for purposes of the comparison required by this paragraph, the comparison may be based on such alternative data.

(b) Other procedures. These are procedures subject to the allowable charge method that are not included in either the overpriced procedures group or the primary care procedures group.

(c) Primary care procedures. These are primary care procedures, excluding overpriced procedures. The CHAMPUS definition of primary care includes maternity care and delivery services and well baby care services.

(2) Step 2: calculating appropriate charge levels. For each year, appropriate charge levels will be calculated by adjusting the prior year's appropriate charge levels as follows:

(a) For overpriced procedures, the prior year's appropriate charge level for each procedure shall be reduced by the lesser of: the percentage by which it exceeds 150 percent of the Medicare converted relative value unit or fifteen percent.

(b) For other procedures, the prior year's appropriate charge level for each procedure shall be continued.

(c) For primary care procedures, the prior year's appropriate charge level shall be adjusted by the Medicare Economic Index (MEI), as the MEI is applied to Medicare prevailing charge levels.

d. Calculating prevailing charge levels and appropriate charge levels for localities. The national prevailing charge levels determined pursuant to paragraph G.1.b. of this section and the national appropriate charge levels calculated pursuant to paragraph G.1.c. of this section will be adjusted for localities using the same (or similar) geographical areas and the same geographic adjustment factors as are used for determining allowable charges under Medicare.

e. Special rules for 1991.

(1) Appropriate charge levels for care provided on or after January 1, 1991, and before the 1992 appropriate charge levels take effect shall be the same as those in effect on December 31, 1990, except that appropriate charge levels for care provided on or after October 7, 1991 shall be those established pursuant to this paragraph G.1.e. of this section.

(2) Appropriate charge levels will be established for each locality for which an appropriate charge level was in effect immediately prior to

October 7, 1991. For each procedure, the appropriate charge level shall be the appropriate charge level in effect immediately prior to October 7, 1991, adjusted as provided in G.1.e.(2)(a) through (c) of this section.

(a) For each overpriced procedure, the level shall be reduced by fifteen percent. For this purpose, overpriced procedures are the procedures determined by the Physician Payment Review Commission to be overvalued pursuant to the process established under the Medicare program, other procedures considered overvalued in the Medicare program (for which Congress directed reductions in Medicare allowable levels for 1991), radiology procedures and pathology procedures.

(b) For each other procedure, the level shall remain unchanged. For this purpose, other procedures are procedures which are not overpriced procedures or primary care procedures.

(c) For each primary care procedure, the level shall be adjusted by the MEI, as the MEI is applied to Medicare prevailing charge levels. For this purpose, primary care procedures include maternity care and delivery services and well baby care services.

(3) For purposes of this paragraph G.1.e., "appropriate charge levels" in effect at any time prior to October 7, 1991 shall mean the lesser of:

(a) The prevailing charge levels then in effect, or

(b) The fiscal year 1988 prevailing charge levels adjusted by the Medicare Economic Index (MEI) was applied beginning in fiscal year 1989.

f. Special transition rule for 1992.

(1) For purposes of calculating the national appropriate charge levels for 1992, the prior year's appropriate charge level for each service will be considered to be the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period of July 1, 1986 to June 30, 1987 (determined as under paragraph G.1.b.(2) of this section), adjusted to calendar year 1991 based on the adjustments made for maximum CHAMPUS allowable charge levels through 1990 and the application of paragraph G.1.e. of this section for 1991.

(2) The adjustment to calendar year 1991 of the product of paragraph G.1.f.(1) of this section shall be as follows:

(a) For procedures other than those described in paragraph G.1.f.(2)(b) of this section, the adjustment to 1991 shall be on the same basis as that provided under paragraph G.1.e. of this section.

(b) For any procedure that was considered an overpriced procedure for purposes of the 1991 prevailing charge levels under paragraph G.1.e. of this section for which the resulting 1991 prevailing charge level was less than 150 percent of the Medicare converted relative value unit, the

adjustment to 1991 for purposes of the special transition rule for 1992 shall be as if the procedure had been treated under paragraph G.1.e.(2)(b) of this section for purposes of the 1991 prevailing charge level.

g. Adjustments and procedural rules.

(1) The Director, OCHAMPUS may make adjustments to the appropriate charge levels calculated pursuant to paragraphs G.1.c. and G.1.e. of this section to correct any anomalies resulting from data or statistical factors, significant differences between Medicare-relevant information and CHAMPUS-relevant considerations or other special factors that fairness requires be specially recognized. However, no such adjustment may result in reducing an appropriate charge level.

(2) The Director, OCHAMPUS will issue procedural instructions for administration of the allowable charge method.

h. A charge that exceeds the prevailing charge can be determined to be allowable only when unusual circumstances or medical complications justify the higher charge. The allowable charge may not exceed the billed charge under any circumstances.

i. The allowable charge for physician assistant services other than assistant-at-surgery may not exceed 85 percent of the allowable charge for a comparable service rendered by a physician performing the service in a similar location. For cases in which the physician assistant and the physician perform component services of a procedure other than assistant-at-surgery (e.g., home, office or hospital visit), the combined allowable charge for the procedure may not exceed the allowable charge for the procedure rendered by a physician alone. The allowable charge for physician assistant services performed as an assistant-at-surgery may not exceed 65 percent of the allowable charge for a physician serving as an assistant surgeon when authorized as CHAMPUS benefits in accordance with the provisions of Chapter 4 C.3.c. of this Part. Physician assistant services must be billed through the employing physician who must be an authorized CHAMPUS provider.

2. All-inclusive rate. Claims from individual health-care professional providers for services rendered to CHAMPUS beneficiaries residing in an RTC that is either being reimbursed on an all-inclusive per diem rate, or is billing an all-inclusive per diem rate, shall be denied; with the exception of independent health-care professionals providing geographically distant family therapy to a family member residing a minimum of 250 miles from the RTC or covered medical services related to a nonmental health condition rendered outside the RTC. Reimbursement for individual professional services is included in the rate paid the institutional provider.

3. Alternative method. The Director, OCHAMPUS, or a designee, may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to ensure a high level of acceptance of the CHAMPUS-determined charge by the individual health-care professionals or other noninstitutional health-care providers furnishing services and supplies to CHAMPUS beneficiaries.

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Alternative methods may not result in reimbursement greater than the allowable charge method above.

H. REIMBURSEMENT UNDER THE MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM

The Military-Civilian Health Services Partnership Program, as authorized by Section 1096, Chapter 55, Title 10, provides for the sharing of staff, equipment, and resources between the civilian and military health care system in order to achieve more effective, efficient, or economical health care for authorized beneficiaries. Military treatment facility commanders, based upon the authority provided by their respective Surgeons General of the military departments, are responsible for entering into individual partnership agreements only when they have determined specifically that use of the Partnership Program is more economical overall to the Government than referring the need for health care services to the civilian community under the normal operation of the CHAMPUS Program. (See Section P. of Chapter 1, for general requirements of the Partnership Program.)

1. Reimbursement of institutional health care providers. Reimbursement of institutional health care providers under the Partnership Program shall be on the same basis as non-Partnership providers.

2. Reimbursement of individual health-care professionals and other non-institutional health care providers. Reimbursement of individual health care professional and other non-institutional health care providers shall be on the same basis as non-Partnership providers as detailed in Section G. of this chapter.

I. ACCOMMODATION OF DISCOUNTS UNDER PROVIDER REIMBURSEMENT METHODS

1. General rule. The Director, OCHAMPUS (or designee) has authority to reimburse a provider at an amount below the amount usually paid pursuant to this chapter when, under a program approved by the Director, the provider has agreed to the lower amount.

2. Special applications. The following are examples of applications of the general rule; they are not all inclusive.

a. In the case of individual health care professionals and other noninstitutional providers, if the discounted fee is below the provider's normal billed charge and the prevailing charge level (see section G. of this chapter), the discounted fee shall be the provider's actual billed charge and the CHAMPUS allowable charge.

b. In the case of institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under subsection A.1. of this chapter or per-diem amount under subsection A.2. of this chapter), if the discount rate is lower than the pre-set rate, the discounted rate shall be the CHAMPUS-determined allowable cost. This is an exception to the usual rule that the pre-set rate is paid regardless of the institutional provider's billed charges or other factors.

3. Procedures.

a. This section only applies when both the provider and the Director have agreed to the discounted payment rate. The Director's agreement may be in the context of approval of a program that allows for such discounts.

b. The Director of OCHAMPUS may establish uniform terms, conditions and limitations for this payment method in order to avoid administrative complexity.

J. OUTSIDE THE UNITED STATES

The Director, OCHAMPUS, or a designee, shall determine the appropriate reimbursement method or methods to be used in the extension of CHAMPUS benefits for otherwise covered medical services or supplies provided by hospitals or other institutional providers, physicians or other individual professional providers, or other providers outside the United States.

K. IMPLEMENTING INSTRUCTIONS

The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this chapter.

DEPARTMENT OF DEFENSE
PUBLICATION SYSTEM
CHANGE TRANSMITTAL

OFFICE OF THE SECRETARY OF DEFENSE
Assistant Secretary of Defense (Health Affairs)

CHANGE NO. 3
to July 1991, Reprint
DoD 6010.8-R
February 7, 1992

CIVILIAN HEALTH AND MEDICAL PROGRAM
OF THE UNIFORMED SERVICES (CHAMPUS)

The Assistant Secretary of Defense (Health Affairs), has authorized the following page changes to DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," July 1991 (Reprint).

PAGE CHANGES

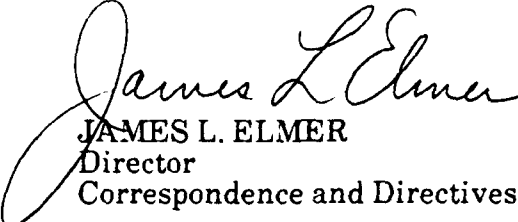
Remove: 2-i through 2-iv, 2-11 through 2-14, 2-21 through 2-26, 4-6a&4-6b,
4-26&4-27, 6-i through 6-20, 7-i through 7-12, 10-i through 10-2

Insert: Attached replacement pages and new pages 6-21 through 6-31, 7-13 through
7-15, 10-2a&10-2b

Changes appear on pages 2-ii, 2-iv, 2-12, 2-13, 2-22, 2-23, 4-6a, 4-26, 6-i&6-ii, 6-1, 6-4,
6-5, 6-11, 6-12, 7-i through 7-1, 7-3 through 7-10 and are indicated by marginal bars.

EFFECTIVE DATE

The effective date for Medical Documentation is December 26, 1991. The effective date
for Drug and Appropriate Level of Care Provisions is November 26, 1991.


JAMES L. ELMER
Director
Correspondence and Directives

Attachments
75 pages

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, THIS TRANSMITTAL SHOULD BE FILED WITH THE BASIC DOCUMENT

CHAPTER 2

DEFINITIONS

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Doctor of Medicine (M.D.). A person who has graduated from a college of allopathic medicine and who is entitled legally to use the designation M.D.

Doctor of Osteopathy (D.O.). A practitioner of osteopathy, that is, a system of therapy based on the theory that the body is capable of making its own remedies against disease and other toxic conditions when it is in normal structural relationship and has favorable environmental conditions and adequate nutrition. It utilizes generally accepted physical, medicinal, and surgical methods of diagnosis and therapy, while placing chief emphasis on the importance of normal body mechanics and manipulative methods of detecting and correcting faulty structure.

Domiciliary Care. Inpatient institutional care provided the beneficiary not because it is medically necessary, but because the care in the home setting is not available, is unsuitable, or members of the patient's family are unwilling to provide the care. Institutionalization because of abandonment constitutes domiciliary care.

NOTE: The terms "domiciliary" and "custodial care" represent separate concepts and are not interchangeable. Domiciliary care is not covered under either the CHAMPUS Basic Program or the Program for the Handicapped (PFTH).

Donor. An individual who supplies living tissue or material to be used in another body, such as a person who furnishes a kidney for renal transplant.

Double Coverage. When a CHAMPUS beneficiary also is enrolled in another insurance, medical service, or health plan that duplicates all or part of a beneficiary's CHAMPUS benefits.

Double Coverage Plan. The specific insurance, medical service, or health plan under which a CHAMPUS beneficiary has entitlement to medical benefits that duplicate CHAMPUS benefits in whole or in part. Double coverage plans donot include:

1. Medicaid.
2. Coverage specifically designed to supplement CHAMPUS benefits.
3. Entitlement to receive care from the Uniformed Services medical facilities; or
4. Entitlement to receive care from Veterans Administration medical care facilities.

Dual Compensation. Federal Law (5 U.S.C. 5536) prohibits active duty members or civilian employees of the United States Government from receiving additional compensation from the government above their normal pay and allowances. This prohibition applies to CHAMPUS cost-sharing of medical care provided by active duty members or civilian government employees to CHAMPUS beneficiaries.

Durable Medical Equipment. Equipment for which the allowable charge is over \$100 and which:

1. Is medically necessary for the treatment of a covered illness or injury;
2. Improves the function of a malformed, diseased, or injured body part, or retards further deterioration of a patient's physical condition;
3. Is used primarily and customarily to serve a medical purpose rather than primarily for transportation, comfort, or convenience;
4. Can withstand repeated use;
5. Provides the medically appropriate level of performance and quality for the medical condition present (that is, nonluxury and nondeluxe); and
6. Is other than spectacles, eyeglasses, contact lenses, or other optical devices, hearing aids, or other communication devices.
7. Is other than exercise equipment, spas, whirlpools, hot tubs, swimming pools or other such items.

Emergency Inpatient Admission. An unscheduled, unexpected, medically necessary admission to a hospital or other authorized institutional provider for treatment of a medical condition meeting the definition of medical emergency and which is determined to require immediate inpatient treatment by the attending physician.

Entity. For purposes of Chapter 9.F.1., "entity" includes a corporation, trust, partnership, sole proprietorship or other kind of business enterprise that is or may be eligible to receive reimbursement either directly or indirectly from CHAMPUS.

Essentials of Daily Living. Care that consists of providing food (including special diets), clothing, and shelter; personal hygiene services; observation and general monitoring; bowel training or management; safety precautions; general preventive procedures (such as turning to prevent bedsores); passive exercise; companionship; recreation; transportation; and such other elements of personal care that reasonably can be performed by an untrained adult with minimal instruction or supervision.

Experimental. Medical care that essentially is investigatory or an unproven procedure or treatment regimen (usually performed under controlled medicolegal conditions) that does not meet the generally accepted standards of usual professional medical practice in the general medical community. The conduct of biomedical or behavioral research involving human subjects at risk of physical, psychological, or social injury is experimental medicine. For the purposes of CHAMPUS, any medical services or supplies provided under a scientific research grant, either public or private, are classified as "experimental." (Financial grants-in-aid to an individual beneficiary are not considered grants for this purpose.) Use of drugs and medicines and devices not approved by the U.S. Food and Drug Administration (FDA) for commercial marketing, that is, for general use by humans (even though permitted for testing on human beings) also is considered experimental. Drugs grandfathered by the Federal Food, Drug and Cosmetic Act of 1938 may

be covered under CHAMPUS as if FDA approved. Certain cancer drugs, designated as Group C drugs (approved and distributed by the National Cancer Institute) and Treatment Investigational New Drugs (INDs), cannot be cost-shared under CHAMPUS because they are not approved for commercial marketing by the FDA. However, medical care related to the use of Group C drugs and Treatment INDs can be cost-shared under CHAMPUS when the patient's medical condition warrants their administration and the care is provided in accordance with generally accepted standards of medical practice. NOTE: In areas outside the United States, standards comparable to those of the FDA are the CHAMPUS objective.

External Partnership Agreement. The external partnership agreement is an agreement between a military treatment facility commander and a CHAMPUS authorized institutional provider, enabling Uniformed Services health care personnel to provide otherwise covered medical care to CHAMPUS beneficiaries in a civilian facility under the Military-Civilian Health Services Partnership Program. Authorized costs associated with the use of the facility will be financed through CHAMPUS under normal cost-sharing and reimbursement procedures currently applicable under the basic CHAMPUS.

Extramedical Individual Providers of Care. Individuals who do counseling or nonmedical therapy and whose training and therapeutic concepts are outside the medical field, as specified in Chapter 6 of this Regulation.

Fraud. For purposes of this Regulation, fraud is defined as 1) a deception or misrepresentation by a provider, beneficiary, sponsor, or any person acting on behalf of a provider, sponsor, or beneficiary with the knowledge (or who had reason to know or should have known) that the deception or misrepresentation could result some unauthorized CHAMPUS benefit to self or some other person, or some unauthorized CHAMPUS payment, or 2) a claim that is false or fictitious, or includes or is supported by any written statement which asserts a material fact which is false or fictitious, or includes or is supported by any written statement that (a) omits a material fact and (b) is false or fictitious as a result of such omission and (c) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact. It is presumed that, if a deception or misrepresentation is established and a CHAMPUS claim is filed, the person responsible for the claim had the requisite knowledge. This presumption is rebuttable only by substantial evidence. It is further presumed that the provider of the services is responsible for the actions of all individuals who file a claim on behalf of the provider (for example, billing clerks); this presumption may only be rebutted by clear and convincing evidence.

Freestanding. Not "institution-affiliated" or "institution-based."

Former Spouse. A former husband or wife of a Uniformed Service member or former member who meets the criteria as set forth in paragraph B.2.b. of Chapter 3 of this Regulation.

Full-Time Course of Higher Education. A complete, progressive series of studies to develop attributes such as knowledge, skill, mind, and character, by formal schooling at a college or university, and which meets the criteria set out in Chapter 3 of this Regulation. To qualify as full-time, the student must be carrying a course load of a minimum of 12 credit hours or equivalent each semester.

General Staff Nursing Service. All nursing care (other than that provided by private duty nurses) including, but not limited to, general duty nursing, emergency room nursing, recovery room nursing, intensive nursing care, and group nursing arrangements performed by nursing personnel on the payroll of the hospital or other authorized institution.

Good Faith Payments. Those payments made to civilian sources of medical care who provided medical care to persons purporting to be eligible beneficiaries but who are determined later to be ineligible for CHAMPUS benefits. (The ineligible person usually possesses an erroneous or illegal identification card.) To be considered for good faith payments, the civilian source of care must have exercised reasonable precautions in identifying a person claiming to be an eligible beneficiary.

High-risk pregnancy. A pregnancy is high-risk when the presence of a currently active or previously treated medical, anatomical, physiological illness or condition may create or increase the likelihood of a detrimental effect on the mother, fetus, or newborn and presents a reasonable possibility of the development of complications during labor or delivery.

Hospital, Acute Care (General and Special). An institution that meets the criteria as set forth in paragraph B.4.a. of Chapter 6 of this Regulation.

Hospital, Long-Term (Tuberculosis, Chronic Care, or Rehabilitation). An institution that meets the criteria as set forth in paragraph B.4. of Chapter 6 of this Regulation.

Hospital, Psychiatric. An institution that meets the criteria as set forth in paragraph B.4. of Chapter 6 of this Regulation.

Illegitimate Child. A child not recognized as a lawful offspring; that is, a child born of parents not married to each other.

Immediate Family. The spouse, natural parent, child and sibling, adopted child and adoptive parent, stepparent, stepchild, grandparent, grandchild, stepbrother and stepsister, father-in-law, mother-in-law of the beneficiary, or provider, as appropriate. For purposes of this definition only, to determine who may render services to a beneficiary, the step-relationship continues to exist even if the marriage upon which the relationship is based terminates through divorce or death of one of the parents.

Independent Laboratory. A freestanding laboratory approved for participation under Medicare and certified by the Health Care Financing Administration.

Infirmaries. Facilities operated by student health departments of colleges and universities to provide inpatient or outpatient care to enrolled students. When specifically approved by the Director, OCHAMPUS, or a designee, a boarding school infirmary also is included.

Initial Determination. A formal written decision on a CHAMPUS claim, a request for benefit authorization, a request by a provider for approval as an authorized CHAMPUS provider, or a decision disqualifying or excluding a provider as an authorized provider under CHAMPUS. Rejection of a claim or a

Participating Provider. A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished services or supplies to a CHAMPUS beneficiary and that has agreed, by act of signing and submitting a CHAMPUS claim form and indicating participation in the appropriate space on the claim form, to accept the CHAMPUS-determined allowable cost or charge as the total charge (even though less than the actual billed amount), whether paid for fully by the CHAMPUS allowance or requiring cost-sharing by the beneficiary (or sponsor).

Party to a Hearing. An appealing party or parties and CHAMPUS.

Party to the Initial Determination. Includes CHAMPUS and also refers to a CHAMPUS beneficiary and a participating provider of services whose interests have been adjudicated by the initial determination. In addition, a provider who has been denied approval as an authorized CHAMPUS provider is a party to that initial determination, as is a provider who is disqualified or excluded as an authorized provider under CHAMPUS, unless the provider is excluded based on a determination of abuse or fraudulent practices or procedures under another federal or federally funded program. See Chapter 10 for additional information concerning parties not entitled to administrative review under the CHAMPUS appeals and hearing procedures.

Pharmacist. A person who is trained specially in the scientific basis of pharmacology and who is licensed to prepare and sell or dispense drugs and compounds and to make up prescriptions ordered by a physician.

Physical Medicine Services or Physiatry Services. The treatment of disease or injury by physical means such as massage, hydrotherapy, or heat.

Physical Handicap. A physical condition of the body that meets the following criteria:

1. Duration. The condition is expected to result in death, or has lasted, or with reasonable certainty is expected to last, for a minimum period of 12 months; and
2. Extent. The condition is of such severity as to preclude the individual from engaging in substantially basic productive activities of daily living expected of unimpaired persons of the same age group.

Physical Therapist. A person who is trained specially in the skills and techniques of physical therapy (that is, the treatment of disease by physical agents and methods such as heat, massage, manipulation, therapeutic exercise, hydrotherapy, and various forms of energy such as electrotherapy and ultrasound), who has been authorized legally (that is, registered) to administer treatments prescribed by a physician and who is entitled legally to use the designation "Registered Physical Therapist." A physical therapist also may be called a physiotherapist.

Physician. A person with a degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is licensed to practice medicine by an appropriate authority.

Podiatrist (Doctor of Podiatry or Surgical Chiropody). A person who has received a degree in podiatry (formerly called chiropody), that is, that specialized field of the healing arts that deals with the study and care of the foot, including its anatomy, pathology, and medical and surgical treatment.

Preauthorization. A decision issued in writing by the Director, OCHAMPUS, or a designee, that CHAMPUS benefits are payable for certain services that a beneficiary has not yet received.

Prescription Drugs and Medicines. Drugs and medicines which at the time of use were approved for commercial marketing by the U.S. Food and Drug Administration, and which, by law of the United States, require a physician's or dentist's prescription, except that it includes insulin for known diabetics whether or not a prescription is required. Drugs grandfathered by the Federal Food, Drug and Cosmetic Act of 1938 may be covered under CHAMPUS as if FDA approved.

NOTE: The fact that the U.S. Food and Drug Administration has approved a drug for testing on humans would not qualify it within this definition.

Preventive Care. Diagnostic and other medical procedures not related directly to a specific illness, injury, or definitive set of symptoms, or obstetrical care, but rather performed as periodic health screening, health assessment, or health maintenance.

Primary Payer. The plan or program whose medical benefits are payable first in a double coverage situation.

Private Duty (Special) Nursing Services. Skilled nursing services rendered to an individual patient requiring intensive medical care. Such private duty (special) nursing must be by an actively practicing registered nurse (R.N.) or licensed practical or vocational nurse (L.P.N. or L.V.N.) only when the medical condition of the patient requires intensive skilled nursing services (rather than primarily providing the essentials of daily living) and when such skilled nursing care is ordered by the attending physician.

Private Room. A room with one bed that is designated as a private room by the hospital or other authorized institutional provider.

Program for the Handicapped (PFTH). The special program set forth in Chapter 5 of this Regulation, through which dependents of active duty members receive supplemental benefits for the moderately or severely mentally retarded and the seriously physically handicapped over and above those medical benefits available under the Basic Program.

Progress notes. Progress notes are an essential component of the medical record wherein health care personnel provide written evidence of ordered and supervised diagnostic tests, treatments, medical procedures, therapeutic behavior and outcomes. In the case of mental health care, progress notes must include: the date of the therapy session; length of the therapy session; a notation of the patient's signs and symptoms; the issues, pathology and specific behaviors addressed in the therapy session; a statement summarizing the therapeutic interventions attempted during the therapy session; descriptions of the response to treatment, the outcome of the treatment, and the response to significant others; and a statement summarizing the patient's degree of progress toward the treatment goals. Progress notes do not need to repeat all that was said during a therapy session but must document a patient contact and be sufficiently detailed to allow for both peer review and audits to substantiate the quality and quantity of care rendered.

Prosthetic Device (Prosthesis). An artificial substitute for a missing body part.

Provider. A hospital or other institutional provider, a physician, or other individual professional provider, or other provider of services or supplies as specified in Chapter 6 of this Regulation.

Provider Exclusion and Suspension. The terms "exclusion" and "suspension", when referring to a provider under CHAMPUS, both mean the denial of status as an authorized provider, resulting in items, services, or supplies furnished by the provider not being reimbursed, directly or indirectly, under CHAMPUS. The terms may be used interchangeably to refer to a provider who has been denied status as an authorized CHAMPUS provider based on 1) a criminal conviction or civil judgment involving fraud, 2) an administrative finding of fraud or abuse under CHAMPUS, 3) an administrative finding that the provider has been excluded or suspended by another agency of the Federal Government, a state, or a local licensing authority, 4) an administrative finding that the provider has knowingly participated in a conflict of interest situation, or 5) an administrative finding that it is in the best interests of the CHAMPUS or CHAMPUS beneficiaries to exclude or suspend the provider.

Provider Termination. When a provider's status as an authorized CHAMPUS provider is ended, other than through exclusion or suspension, based on a finding that the provider does not meet the qualifications, as set forth in Chapter 6 of this Regulation, to be an authorized CHAMPUS provider.

Radiation Therapy Services. The treatment of diseases by x-ray, radium, or radioactive isotopes when ordered by the attending physician.

Referral. The act or an instance of referring a CHAMPUS beneficiary to another authorized provider to obtain necessary medical treatment. Under CHAMPUS, only a physician may make referrals.

Registered Nurse. A person who is prepared specially in the scientific basis of nursing, who is a graduate of a school of nursing, and who is registered for practice after examination by a state board of nurse examiners or similar regulatory authority, who holds a current, valid license, and who is entitled legally to use the designation R.N.

Representative. Any person who has been appointed by a party to the initial determination as counsel or advisor and who is otherwise eligible to serve as the counsel or advisor of the party to the initial determination, particularly in connection with a hearing.

Resident (Medical). A graduate physician or dentist who has an M.D. or D.O. degree, or D.D.S. or D.M.D. degree, respectively, is licensed to practice, and who chooses to remain on the house staff of a hospital to get further training that will qualify him or her for a medical or dental specialty.

Residential Treatment Center (RTC). A facility (or distinct part of a facility) which meets the criteria in Chapter 6.B.4.

Retiree. A member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay based on duty in a Uniformed Service.

Routine Eye Examinations. The services rendered in order to determine the refractive state of the eyes.

Sanction. For purpose of Chapter 9, "sanction" means a provider exclusion, suspension, or termination.

Secondary Payer. The plan or program whose medical benefits are payable in double coverage situations only after the primary payer has adjudicated the claim.

Semiprivate Room. A room containing at least two beds. If a room is designated publicly as a semiprivate accommodation by the hospital or other authorized institutional provider and contains multiple beds, it qualifies as a semiprivate room for the purposes of CHAMPUS.

Skilled Nursing Facility. An institution (or a distinct part of an institution) that meets the criteria as set forth in subsection B.4. of Chapter 6 of this Regulation.

Skilled Nursing Service. A service that can only be furnished by an R.N., or L.P.N. or L.V.N., and is required to be performed under the supervision of a physician to ensure the safety of the patient and achieve the medically desired result. Examples of skilled nursing services are intravenous or intramuscular injections, levin tube or gastrostomy feedings, or tracheotomy aspiration and insertion. Skilled nursing services are other than those services that provide primarily support for the essentials of daily living or that could be performed by an untrained adult with minimum instruction or supervision.

Special Tutoring. Teaching or instruction provided by a private teacher to an individual usually in a private or separate setting to enhance the educational development of an individual in one or more study areas.

Spectacles, Eyeglasses, and Lenses. Lenses, including contact lenses, that help to correct faulty vision.

Sponsor. An active duty member, retiree, or deceased active duty member or retiree, of a Uniformed Service upon whose status his or her dependents' eligibility for CHAMPUS is based.

Spouse. A lawful wife or husband regardless of whether or not dependent upon the active duty member or retiree.

Student Status. A dependent of a member or former member of a Uniformed Service who has not passed his or her 23rd birthday, and is enrolled in a full-time course of study in an institution of higher learning.

Suppliers of Portable X-Ray Services. A supplier that meets the conditions of coverage of the Medicare program, set forth in the Medicare regulations (reference (m)), or the Medicaid program in the state in which the covered service is provided.

Surgery. Medically appropriate operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and those certain procedures listed in paragraph C.2.a. of Chapter 4 of this Regulation.

Surgical Assistant. A physician (or dentist or podiatrist) who assists the operating surgeon in the performance of a covered surgical service when such assistance is certified as necessary by the attending surgeon, when the type of surgical procedure being performed is of such complexity and seriousness as to require a surgical assistant, and when interns, residents, or other house staff are not available to provide the surgical assistance services in the specialty area required.

Suspension of Claims Processing. The temporary suspension of processing (to protect the government's interests) of claims for care furnished by a specific provider (whether the claims are submitted by the provider or beneficiary) or claims submitted by or on behalf of a specific CHAMPUS beneficiary pending action by the Director, OCHAMPUS, or a designee, in a case of suspected fraud or abuse. The action may include the administrative remedies provided for in Chapter 9 or any other Department of Defense issuance (e.g. DoD issuances implementing the Program Fraud Civil Remedies Act), case development or investigation by OCHAMPUS, or referral to the Department of Defense-Inspector General or the Department of Justice for action within their cognizant jurisdictions.

Timely Filing. The filing of CHAMPUS claims within the prescribed time limits as set forth in Chapter 7 of this Regulation.

Treatment Plan. A detailed description of the medical care being rendered or expected to be rendered a CHAMPUS beneficiary seeking approval for inpatient benefits for which preauthorization is required as set forth in section B. of Chapter 4 of this Regulation. A treatment plan must include, at a minimum, a diagnosis (either ICD-9-CM or DSM-III); detailed reports of prior treatment, medical history, family history, social history, and physical examination; diagnostic test results; consultant's reports (if any); proposed treatment by type (such as surgical, medical, and psychiatric); a description of who is or will be providing treatment (by discipline or specialty); anticipated frequency, medications, and specific goals of treatment; type of inpatient facility required and why (including length of time the related inpatient stay will be required); and prognosis. If the treatment plan involves the transfer of a CHAMPUS patient from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the treatment plan documentation.

Uniformed Services. The Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA.

Veteran. A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

NOTE: Unless the veteran is eligible for "retired pay," "retirement pay," or "retainer pay," which refers to payments of a continuing nature and are payable at fixed intervals from the government for military service neither the veteran nor his or her dependents are eligible for benefits under CHAMPUS.

Well-Baby Care. A specific program of periodic health screening, developmental assessment, and routine immunization for children from birth up to 2 years.

Widow or Widower. A person who was a spouse at the time of death of the active duty member or retiree and who has not remarried.

Worker's Compensation Benefits. Medical benefits available under any worker's compensation law (including the Federal Employees Compensation Act), occupational disease law, employers liability law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure.

X-Ray Services. An x-ray examination from which an x-ray film or other image is produced, ordered by the attending physician when necessary and rendered in connection with a medical or surgical diagnosis or treatment of an illness or injury, or in connection with maternity or well-baby care.

DEPARTMENT OF DEFENSE
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to July 1991, Reprint
DoD 6010.8-R
August 14, 1992

CIVILIAN HEALTH AND MEDICAL PROGRAM
OF THE UNIFORMED SERVICES (CHAMPUS)

The Assistant Secretary of Defense (Health Affairs), has authorized the following page changes to DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," July 1991 (Reprint).

PAGE CHANGES

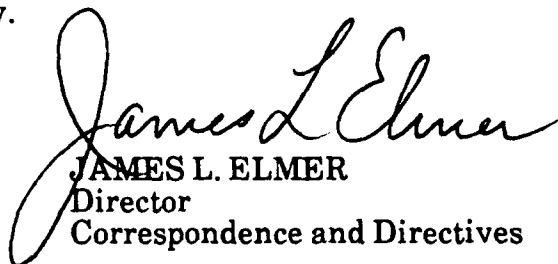
Remove: 2-i through 2-iv, 2-3&2-4, 2-21&2-22, 2-25&2-26, 4-iii&4-iv

Insert: Attached replacement pages and new page 2-v

Changes appear on pages 2-i, 2-iv, 2-4, 2-22, 2-25, 4-iii, 4-6, 4-14, 4-22, 4-23, and 6-23 and are indicated by marginal bars.

EFFECTIVE DATE

The above changes are effective immediately.


JAMES L. ELMER
Director
Correspondence and Directives

Attachments
23 pages

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, THIS TRANSMITTAL SHOULD BE FILED WITH THE BASIC DOCUMENT

CHAPTER 2

DEFINITIONS

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Admission. The formal acceptance by a CHAMPUS authorized institutional provider of a CHAMPUS beneficiary for the purpose of diagnosis and treatment of illness, injury, pregnancy, or mental disorder.

Adopted Child. A child taken into one's own family by legal process and treated as one's own child. In case of adoption, CHAMPUS eligibility begins as of 12:01 a.m. of the day of the final adoption decree. NOTE: There is no CHAMPUS benefit entitlement during any interim waiting period.

All-Inclusive Per Diem Rate. The OCHAMPUS determined rate that encompasses the daily charge for inpatient care and, unless specifically excepted, all other treatment determined necessary and rendered as part of the treatment plan established for a patient, and accepted by OCHAMPUS.

Allowable Charge. The CHAMPUS-determined level of payment to physicians, other individual professional providers and other providers, based on one of the approved reimbursement methods set forth in Chapter 14 of this Regulation. Allowable charge also may be referred to as the CHAMPUS-determined reasonable charge.

Allowable Cost. The CHAMPUS-determined level of payment to hospitals or other institutions, based on one of the approved reimbursement methods set forth in Chapter 14 of this Regulation. Allowable cost may also be referred to as the CHAMPUS-determined reasonable cost.

Ambulance. A specially designed vehicle for transporting the sick or injured that contains a stretcher, linens, first aid supplies, oxygen equipment, and such lifesaving equipment required by state and local law, and that is staffed by personnel trained to provide first aid treatment.

Amount in Dispute. The amount of money, determined under this Regulation, that CHAMPUS would pay for medical services and supplies involved in an adverse determination being appealed if the appeal were resolved in favor of the appealing party. See Chapter 10 for additional information concerning the determination of "amount in dispute" under this Regulation.

Anesthesia Services. The administration of an anesthetic agent by injection or inhalation, the purpose and effect of which is to produce surgical anesthesia characterized by muscular relaxation, loss of sensation, or loss of consciousness when administered by or under the direction of a physician or dentist in connection with otherwise covered surgery or obstetrical care, or shock therapy. Anesthesia services do not include hypnosis or acupuncture.

Appealable Issue. Disputed questions of fact which, if resolved in favor of the appealing party, would result in the authorization of CHAMPUS benefits, or approval as an authorized provider in accordance with this Regulation. An appealable issue does not exist if no facts are in dispute, if no CHAMPUS benefits would be payable, or if there is no authorized provider, regardless of the resolution of any disputed facts. See Chapter 10 for additional information concerning the determination of "appealable issue" under this Regulation.

Appealing Party. Any party to the initial determination who files an appeal of an adverse determination or requests a hearing under the provisions of this Regulation.

Appropriate Medical Care

1. Services performed in connection with the diagnosis or treatment of disease or injury, pregnancy, mental disorder, or well-baby care which are in keeping with the generally accepted norms for medical practice in the United States;

2. The authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training and education and is licensed or certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards; and

3. The services are furnished economically. For purposes of this Regulation, "economically" means that the services are furnished in the least expensive level of care or medical environment adequate to provide the required medical care regardless of whether or not that level of care is covered by CHAMPUS.

Approved teaching programs. For purposes of CHAMPUS, an approved teaching program is a program of graduate medical education which has been duly approved in its respective specialty or subspecialty by the Accreditation Council for Graduate Medical Education of the American Medical Association, by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, by the Council on Dental Education of the American Dental Association, or by the Council on Podiatry Education of the American Podiatry Association.

Attending Physician. The physician who has the primary responsibility for the medical diagnosis and treatment of the patient. A consultant or an assistant surgeon, for example, would not be an attending physician. Under very extraordinary circumstances, because of the presence of complex, serious, and multiple, but unrelated, medical conditions, a patient may have more than one attending physician concurrently rendering medical treatment during a single period of time. An attending physician also may be a teaching physician.

Authorized Provider. A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized to provide benefits under CHAMPUS in Chapter 6 of this Regulation.

Backup Hospital. A hospital which is otherwise eligible as a CHAMPUS institutional provider and which is fully capable of providing emergency care to a patient who develops complications beyond the scope of services of a given category of CHAMPUS authorized freestanding institutional provider and which is accessible from the site of the CHAMPUS authorized freestanding institutional provider within an average transport time acceptable for the types of medical emergencies usually associated with the type of care provided by the freestanding facility.

Basic Program. The primary medical benefits authorized under Chapter 55 of title 10, United States Code, and set forth in Chapter 4 of this Regulation.

Beneficiary. An individual who has been determined to be eligible for CHAMPUS benefits, as set forth in Chapter 3 of this Regulation.

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Participating Provider. A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished services or supplies to a CHAMPUS beneficiary and that has agreed, by act of signing and submitting a CHAMPUS claim form and indicating participation in the appropriate space on the claim form, to accept the CHAMPUS-determined allowable cost or charge as the total charge (even though less than the actual billed amount), whether paid for fully by the CHAMPUS allowance or requiring cost-sharing by the beneficiary (or sponsor).

Party to a Hearing. An appealing party or parties and CHAMPUS.

Party to the Initial Determination. Includes CHAMPUS and also refers to a CHAMPUS beneficiary and a participating provider of services whose interests have been adjudicated by the initial determination. In addition, a provider who has been denied approval as an authorized CHAMPUS provider is a party to that initial determination, as is a provider who is disqualified or excluded as an authorized provider under CHAMPUS, unless the provider is excluded based on a determination of abuse or fraudulent practices or procedures under another federal or federally funded program. See Chapter 10 for additional information concerning parties not entitled to administrative review under the CHAMPUS appeals and hearing procedures.

Pharmacist. A person who is trained specially in the scientific basis of pharmacology and who is licensed to prepare and sell or dispense drugs and compounds and to make up prescriptions ordered by a physician.

Physical Medicine Services or Physiatry Services. The treatment of disease or injury by physical means such as massage, hydrotherapy, or heat.

Physical Handicap. A physical condition of the body that meets the following criteria:

1. Duration. The condition is expected to result in death, or has lasted, or with reasonable certainty is expected to last, for a minimum period of 12 months; and
2. Extent. The condition is of such severity as to preclude the individual from engaging in substantially basic productive activities of daily living expected of unimpaired persons of the same age group.

Physical Therapist. A person who is trained specially in the skills and techniques of physical therapy (that is, the treatment of disease by physical agents and methods such as heat, massage, manipulation, therapeutic exercise, hydrotherapy, and various forms of energy such as electrotherapy and ultrasound), who has been authorized legally (that is, registered) to administer treatments prescribed by a physician and who is entitled legally to use the designation "Registered Physical Therapist." A physical therapist also may be called a physiotherapist.

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Physician. A person with a degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is licensed to practice medicine by an appropriate authority.

Physician in training. Interns, residents, and fellows participating in approved postgraduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital or other institutional provider setting, e.g., individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools.

Podiatrist (Doctor of Podiatry or Surgical Chiropody). A person who has received a degree in podiatry (formerly called chiropody), that is, that specialized field of the healing arts that deals with the study and care of the foot, including its anatomy, pathology, and medical and surgical treatment.

Preauthorization. A decision issued in writing by the Director, OCHAMPUS, or a designee, that CHAMPUS benefits are payable for certain services that a beneficiary has not yet received.

Prescription Drugs and Medicines. Drugs and medicines which at the time of use were approved for commercial marketing by the U.S. Food and Drug Administration, and which, by law of the United States, require a physician's or dentist's prescription, except that it includes insulin for known diabetics whether or not a prescription is required. Drugs grandfathered by the Federal Food, Drug and Cosmetic Act of 1938 may be covered under CHAMPUS as if FDA approved.

NOTE: The fact that the U.S. Food and Drug Administration has approved a drug for testing on humans would not qualify it within this definition.

Preventive Care. Diagnostic and other medical procedures not related directly to a specific illness, injury, or definitive set of symptoms, or obstetrical care, but rather performed as periodic health screening, health assessment, or health maintenance.

Primary Payer. The plan or program whose medical benefits are payable first in a double coverage situation.

Private Duty (Special) Nursing Services. Skilled nursing services rendered to an individual patient requiring intensive medical care. Such private duty (special) nursing must be by an actively practicing registered nurse (R.N.) or licensed practical or vocational nurse (L.P.N. or L.V.N.) only when the medical condition of the patient requires intensive skilled nursing services (rather than primarily providing the essentials of daily living) and when such skilled nursing care is ordered by the attending physician.

Private Room. A room with one bed that is designated as a private room by the hospital or other authorized institutional provider.

Program for the Handicapped (PFTH). The special program set forth in Chapter 5 of this Regulation, through which dependents of active duty members receive supplemental benefits for the moderately or severely mentally retarded and the seriously physically handicapped over and above those medical benefits available under the Basic Program.

Special Tutoring. Teaching or instruction provided by a private teacher to an individual usually in a private or separate setting to enhance the educational development of an individual in one or more study areas.

Spectacles, Eyeglasses, and Lenses. Lenses, including contact lenses, that help to correct faulty vision.

Sponsor. An active duty member, retiree, or deceased active duty member or retiree, of a Uniformed Service upon whose status his or her dependents' eligibility for CHAMPUS is based.

Spouse. A lawful wife or husband regardless of whether or not dependent upon the active duty member or retiree.

Student Status. A dependent of a member or former member of a Uniformed Service who has not passed his or her 23rd birthday, and is enrolled in a full-time course of study in an institution of higher learning.

Suppliers of Portable X-Ray Services. A supplier that meets the conditions of coverage of the Medicare program, set forth in the Medicare regulations (reference (m)), or the Medicaid program in the state in which the covered service is provided.

Surgery. Medically appropriate operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and those certain procedures listed in paragraph C.2.a. of Chapter 4 of this Regulation.

Surgical Assistant. A physician (or dentist or podiatrist) who assists the operating surgeon in the performance of a covered surgical service when such assistance is certified as necessary by the attending surgeon, when the type of surgical procedure being performed is of such complexity and seriousness as to require a surgical assistant, and when interns, residents, or other house staff are not available to provide the surgical assistance services in the specialty area required.

Suspension of Claims Processing. The temporary suspension of processing (to protect the government's interests) of claims for care furnished by a specific provider (whether the claims are submitted by the provider or beneficiary) or claims submitted by or on behalf of a specific CHAMPUS beneficiary pending action by the Director, OCHAMPUS, or a designee, in a case of suspected fraud or abuse. The action may include the administrative remedies provided for in Chapter 9 or any other Department of Defense issuance (e.g. DoD issuances implementing the Program Fraud Civil Remedies Act), case development or investigation by OCHAMPUS, or referral to the Department of Defense-Inspector General or the Department of Justice for action within their cognizant jurisdictions.

Teaching physician. A teaching physician is any physician whose duties include providing medical training to physicians in training within a hospital or other institutional provider setting.

Timely Filing. The filing of CHAMPUS claims within the prescribed time limits as set forth in Chapter 7 of this Regulation.

Treatment Plan. A detailed description of the medical care being rendered or expected to be rendered a CHAMPUS beneficiary seeking approval for inpatient benefits for which preauthorization is required as set forth in section B. of Chapter 4 of this Regulation. A treatment plan must include, at a minimum, a diagnosis (either ICD-9-CM or DSM-III); detailed reports of prior treatment, medical history, family history, social history, and physical examination; diagnostic test results; consultant's reports (if any); proposed treatment by type (such as surgical, medical, and psychiatric); a description of who is or will be providing treatment (by discipline or specialty); anticipated frequency, medications, and specific goals of treatment; type of inpatient facility required and why (including length of time the related inpatient stay will be required); and prognosis. If the treatment plan involves the transfer of a CHAMPUS patient from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the treatment plan documentation.

Uniformed Services. The Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA.

Veteran. A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

NOTE: Unless the veteran is eligible for "retired pay," "retirement pay," or "retainer pay," which refers to payments of a continuing nature and are payable at fixed intervals from the government for military service neither the veteran nor his or her dependents are eligible for benefits under CHAMPUS.

Well-Baby Care. A specific program of periodic health screening, developmental assessment, and routine immunization for children from birth up to 2 years.

Widow or Widower. A person who was a spouse at the time of death of the active duty member or retiree and who has not remarried.

Worker's Compensation Benefits. Medical benefits available under any worker's compensation law (including the Federal Employees Compensation Act), occupational disease law, employers liability law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure.

X-Ray Services. An x-ray examination from which an x-ray film or other image is produced, ordered by the attending physician when necessary and rendered in connection with a medical or surgical diagnosis or treatment of an illness or injury, or in connection with maternity or well-baby care.

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c. Documentation for preauthorization - approved treatment plan. A request for preauthorization described in subsection A.11. of this chapter, requires submission of a detailed treatment plan, in accordance with guidelines and procedures issued by the Director, OCHAMPUS.

d. Other preauthorization requirements

(1) The Director, OCHAMPUS, or a designee, shall respond to all requests for preauthorization in writing and shall send notification of approval or denial to the beneficiary.

(2) The Director, OCHAMPUS, or a designee, shall specify, in the approved preauthorization, the services and supplies the approval covers.

(3) An approved preauthorization is valid only for 90 days from the date of issuance. If the preauthorized services and supplies are not obtained or commenced within the 90-day period, a new preauthorization request is required.

(4) A preauthorization may set forth other special limits or requirements as indicated by the particular case or situation for which preauthorization is being issued.

12. Utilization review, quality assurance and preauthorization for inpatient mental health services.

a. In general. The Director, OCHAMPUS shall provide, either directly or through contract, a program of utilization and quality review for all mental health care services. Among other things, this program shall include mandatory preadmission authorization before nonemergency inpatient mental health services may be provided and mandatory approval of continuation of inpatient services within 72 hours of emergency admissions. This program shall also include requirements for other pretreatment authorization procedures, concurrent review of continuing inpatient and outpatient care, retrospective review, and other such procedures as determined appropriate by the Director, OCHAMPUS. The provisions of paragraph H of this chapter and paragraph F, Chapter 15, shall apply to this program. The Director, OCHAMPUS, shall establish, pursuant to paragraph F., Chapter 15, procedures substantially comparable to requirements of paragraph H of this chapter and Chapter 15. If the utilization and quality review program for mental health care services is provided by contract, the contractor(s) need not be the same contractor(s) as are engaged under Chapter 15 in connection with the review of other services.

b. Preadmission authorization.

(1) This section generally requires preadmission authorization for all nonemergency inpatient mental health services and prompt continued stay authorization after emergency admissions. Institutional services for which payment would otherwise be authorized, but which were provided without compliance with preadmission authorization requirements, do not qualify for the same payment that would be provided if the preadmission requirements had been met.

(2) In cases of noncompliance with preadmission authorization requirements, institutional payment will be reduced by the amount attributable to the days of services without the appropriate certification up to a maximum of five days of services. In cases in which payment is determined on a prospectively set per-discharge basis (such as the DRG-based payment system), the reduction shall be \$500 for each day of services provided without the appropriate preauthorization, up to a maximum of five days of services.

(3) For purposes of paragraph A.12.b.(2) of this chapter, a day of services without the appropriate preauthorization is any day of services provided prior to:

- (a) the receipt of an authorization; or
- (b) the effective date of an authorization subsequently received.

(4) Services for which payment is disallowed under paragraph A.12.b.(2) of this chapter may not be billed to the patient (or the patient's family).

13. Implementing instructions. The Director, OCHAMPUS, or a designee, shall issue policies, instructions, procedures, guidelines, standards, or criteria as may be necessary to implement the intent of this Regulation.

B. INSTITUTIONAL BENEFITS

1. General. Services and supplies provided by an institutional provider authorized as set forth in Chapter 6 of this Regulation may be cost-shared only when such services or supplies (i) are otherwise authorized by this Regulation; (ii) are medically necessary; (iii) are ordered, directed, prescribed, or delivered by an OCHAMPUS-authorized individual professional provider as set forth in Chapter 6 of this Regulation or by an employee of the authorized institutional provider who is otherwise eligible to be a CHAMPUS authorized individual professional provider; (iv) are delivered in accordance with generally accepted norms for clinical practice in the United States; (v) meet established quality standards; and (vi) comply with applicable definitions, conditions, limitations, exceptions, or exclusions as otherwise set forth in this Regulation.

a. Billing practices. To be considered for benefits under this section B., covered services and supplies must be provided and billed for by a hospital or other authorized institutional provider. Such billings must be fully itemized and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. Depending on the individual circumstances, teaching physician services may be considered an institutional benefit in accordance with this Section or a professional benefit under Section C. See paragraph C.3.m. of this Chapter for the CHAMPUS requirements regarding teaching physicians. In the case of continuous care, claims shall be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor or, on a participating basis, directly by the facility on behalf of the beneficiary (refer to Chapter 7).

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(4) For patients in care at the time the inpatient limit is reached, a waiver must be requested prior to the limit. For patients being readmitted after having received 30 or 45 days in the fiscal year, the waiver review will be conducted at the time of the preadmission authorization.

d. Acute care day limits do not apply to services provided under the Program for the Handicapped (Chapter 5 of this Regulation) or services provided as partial hospitalization care.

C. PROFESSIONAL SERVICES BENEFIT

1. General. Benefits may be extended for those covered services described in this section C., that are provided in accordance with good medical practice and established standards of quality by physicians or other authorized individual professional providers, as set forth in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, exceptions, limitations, or exclusion as may be otherwise set forth

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in this or other chapters of this Regulation. Except as otherwise specifically authorized, to be considered for benefits under this Section C., the described services must be rendered by a physician, or prescribed, ordered, and referred medically by a physician to other authorized individual professional providers. Further, except under specifically defined circumstances, there should be an attending physician in any episode of care. (For example, certain services of a clinical psychologist are exempt from this requirement. For these exceptions, refer to Chapter 6.)

a. Billing practices. To be considered for benefits under this Section C, covered professional services must be performed personally by the physician or other authorized individual professional provider, who is other than a salaried or contractual staff member of a hospital or other authorized institution, and who ordinarily and customarily bills on a fee-for-service basis for professional services rendered. Such billings must be itemized fully and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. See paragraph C.3.m. of this Chapter for the requirements regarding the special circumstances for teaching physicians. For continuing professional care, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor, or directly by the physician or other authorized individual professional provider on behalf of a beneficiary (refer to Chapter 7 of this Regulation).

b. Services must be related. Covered professional services must be rendered in connection with and directly related to a covered diagnosis or definitive set of symptoms requiring medically necessary treatment.

2. Covered services of physicians and other authorized individual professional providers

a. Surgery. Surgery means operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and the following procedures:

- Bronchoscopy
- Laryngoscopy
- Thoracoscopy
- Catheterization of the heart
- Arteriograph thoracic lumbar
- Esophagoscopy
- Gastrosocopy
- Proctoscopy
- Sigmoidoscopy
- Peritoneoscopy
- Cystoscopy
- Colonoscopy
- Upper G.I. panendoscopy
- Encephalograph
- Myelography
- Discography
- Visualization of intracranial aneurysm by intracarotid injection of dye, with exposure of carotid artery, unilateral

1. Private duty (special) nursing. Benefits are available for the skilled nursing services rendered by a private duty (special) nurse to a beneficiary requiring intensive skilled nursing care that can only be provided with the technical proficiency and scientific skills of an R.N. The specific skilled nursing services being rendered are controlling, not the condition of the patient or the professional status of the private duty (special) nurse rendering the services.

(1) Inpatient private duty (special) nursing services are limited to those rendered to an inpatient in a hospital that does not have an ICU. In addition, under specified circumstances, private duty (special) nursing in the home setting also is covered.

(2) The private duty (special) nursing care must be ordered and certified to be medically necessary by the attending physician.

(3) The skilled nursing care must be rendered by a private duty (special) nurse who is neither a member of the immediate family nor is a member of the beneficiary's household.

(4) Private duty (special) nursing care does not, except incidentally, include providing services that provide or support primarily the essentials of daily living or acting as a companion or sitter.

(5) If the private duty (special) nursing care services being performed are primarily those that could be rendered by the average adult with minimal instruction or supervision, the services would not qualify as covered private duty (special) nursing services, regardless of whether performed by an R.N., regardless of whether or not ordered and certified to by the attending physician, and regardless of the condition of the patient.

(6) In order for such services to be considered for benefits, a private duty (special) nurse is required to maintain detailed daily nursing notes, whether the case involves inpatient nursing service or nursing services rendered in the home setting.

(7) Claims for continuing private duty (special) nursing care shall be submitted at least every 30 days. Each claim will be reviewed and the nursing care evaluated whether it continues to be appropriate and eligible for benefits.

(8) In most situations involving private duty (special) nursing care rendered in the home setting, benefits will be available only for a portion of the care, that is, providing benefits only for that time actually required to perform medically necessary skilled nursing services. If full-time private duty (special) nursing services are engaged, usually for convenience or to provide personal services to the patient, CHAMPUS benefits are payable only for that portion of the day during which skilled nursing services are rendered, but in no event is less than 1 hour of nursing care payable in any 24-hour period during which skilled nursing services are determined to have been rendered. Such situations often are better

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accommodated through the use of visiting nurses. This allows the personal services that are not coverable by CHAMPUS to be obtained at lesser cost from other than an R.N. Skilled nursing services provided by visiting nurses are covered under CHAMPUS.

NOTE: When the services of an R.N. are not available, benefits may be extended for the otherwise covered services of a L.P.N. or L.V.N.

m. Physicians in a teaching setting.

(1) Teaching physicians.

(a) General. The services of teaching physicians may be reimbursed on an allowable charge basis only when the teaching physician has established an attending physician relationship between the teaching physician and the patient or when the teaching physician provides distinct, identifiable, personal services (e.g., services rendered as a consultant, assistant surgeon, etc.). Attending physician services may include both direct patient care services or direct supervision of care provided by a physician in training. In order to be considered an attending physician, the teaching physician must:

1 Review the patient's history and the record of examinations and tests in the institution, and make frequent reviews of the patient's progress; and

2 Personally examine the patient; and

3 Confirm or revise the diagnosis and determine the course of treatment to be followed; and

4 Either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by physicians in training and that the care meets a proper quality level; and

5 Be present and ready to perform any service performed by an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; and

6 Be personally responsible for the patient's care, at least throughout the period of hospitalization.

(b) Direct supervision by an attending physician of care provided by physicians in training. Payment on the basis of allowable charges may be made for the professional services rendered to a beneficiary by his/her attending physician when the attending physician provides personal and identifiable direction to physicians in training who are participating in the care of the patient. It is not necessary that the attending physician be personally present for all services, but the attending physician must be on the provider's premises and available to provide immediate personal assistance and direction if needed.

(c) Individual, personal services. A teaching physician may be reimbursed on an allowable charge basis for any individual, identifiable service rendered to a CHAMPUS beneficiary, so long as the service is a covered service and is normally reimbursed separately, and so long as the patient records substantiate the service.

(d) Who may bill. The services of a teaching physician must be billed by the institutional provider when the physician is employed by the provider or a related entity or under a contract which provides for payment to the physician by the provider or a related entity. Where the teaching physician has no relationship with the provider (except for standard physician privileges to admit patients) and generally treats patients on a fee for service basis in the private sector, the teaching physician may submit claims under his/her own provider number.

(2) Physicians in training. Physicians in training in an approved teaching program are considered to be "students" and may not be reimbursed directly by CHAMPUS for services rendered to a beneficiary when their services are provided as part of their employment (either salaried or contractual) by a hospital or other institutional provider. Services of physicians in training may be reimbursed on an allowable charge basis only if:

(a) The physician in training is fully licensed to practice medicine by the state in which the services are performed, and

(b) The services are rendered outside the scope and requirements of the approved training program to which the physician in training is assigned.

D. OTHER BENEFITS

1. General. Benefits may be extended for the allowable charge of those other covered services and supplies described in this section D., which are provided in accordance with good medical practice and established standards of quality by those other authorized providers described in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, limitations, or exclusions as otherwise may be set forth in this or other chapters of this Regulation. To be considered for benefits under this section D., the described services or supplies must be prescribed and ordered by a physician. Other authorized individual professional providers acting within their scope of licensure may also prescribe and order these services and supplies unless otherwise specified in this section D. For example, durable medical equipment and cardiorespiratory monitors can only be ordered by a physician.

2. Billing practices. To be considered for benefits under this Section D., covered services and supplies must be provided and billed for by an authorized provider as set forth in Chapter 6 of this Regulation. Such billing must be itemized fully and described sufficiently, even when CHAMPUS payment is determined under the CHAMPUS DRG-based payment system, so that CHAMPUS can determine whether benefits are authorized by this Regulation. Except for claims subject to the CHAMPUS DRG-based payment system, whenever continuing charges are involved, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days (monthly) either by the beneficiary or sponsor or directly by the provider. For claims subject to the CHAMPUS DRG-based payment system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

3. Other covered services and supplies

a. Blood. If whole blood or plasma (or its derivatives) are provided and billed for by an authorized institution in connection with covered treatment, benefits are extended as set forth in section B. of this chapter. If blood is billed for directly to a beneficiary, benefits may be extended under this section D. in the same manner as a medical supply.

b. Durable medical equipment

(1) Scope of benefit. Subject to the exceptions in paragraphs (2) and (3) below, only durable medical equipment (DME) which is ordered by a physician for the specific use of the beneficiary, and which complies with the definition of "Durable Medical Equipment" in Chapter 2 of this Regulation, and which is not otherwise excluded by this Regulation qualifies as a Basic Program benefit.

(2) Cardiorespiratory monitor exception.

(a) When prescribed by a physician who is otherwise eligible as a CHAMPUS individual professional provider, or who is on active duty with a United States Uniformed Service, an electronic cardiorespiratory monitor, including technical support necessary for the proper use of the monitor, may be cost-shared as durable medical equipment when supervised by the prescribing physician for in-home use by:

1 An infant beneficiary who has had an apparent life-threatening event, as defined in guidelines issued by the Director, OCHAMPUS, or a designee, or,

2 An infant beneficiary who is a subsequent or multiple birth biological sibling of a victim of sudden infant death syndrome (SIDS), or,

3 An infant beneficiary whose birth weight was 1,500 grams or less, or,

4 An infant beneficiary who is a pre-term infant with pathologic apnea, as defined in guidelines issued by the Director, OCHAMPUS, or a designee, or,

(i) Professional staff. The center's professional staff is legally and professionally qualified for the performance of their professional responsibilities.

(j) Medical records. The center maintains full and complete written documentation of the services rendered to each woman admitted and each newborn delivered. A copy of the informed consent document required by subparagraph (c), above, which contains the original signature of the CHAMPUS beneficiary, signed and dated at the time of admission, must be maintained in the medical record of each CHAMPUS beneficiary admitted.

(k) Quality assurance. The center has an organized program for quality assurance which includes, but is not limited to, written procedures for regularly scheduled evaluation of each type of service provided, of each mother or newborn transferred to a hospital, and of each death within the facility.

(l) Governance and administration. The center has a governing body legally responsible for overall operation and maintenance of the center and a full-time employee who has authority and responsibility for the day-to-day operation of the center.

C. INDIVIDUAL PROFESSIONAL PROVIDERS OF CARE

1. General. Individual professional providers of care are those providers who bill for their services on a fee-for-service basis and who are not employed by an institutional provider or under a contract which provides for payment to the individual professional provider by an institutional provider. This category also includes those individuals who have formed professional corporations or associations qualifying as a domestic corporation under section 301.7701-5 of the Internal Revenue Service Regulations (reference (cc)). Such individual professional providers must be licensed or certified by the local licensing or certifying agency for the jurisdiction in which the care is provided; or in the absence of state licensure/certification, be a member of or demonstrate eligibility for full clinical membership in, the appropriate national or professional certifying association that sets standards for the profession of which the provider is a member. Services provided must be in accordance with good medical practice and prevailing standards of quality of care and within recognized utilization norms.

a. Licensing/Certification required, scope of license. Otherwise covered services shall be cost-shared only if the individual professional provider holds a current, valid license or certification to practice his or her profession in the jurisdiction where the service is rendered. Licensure/certification must be at the full clinical practice level. The services provided must be within the scope of the license, certification or other legal authorization. Licensure or certification is required to be a CHAMPUS authorized provider if offered in the jurisdiction where the service is rendered, whether such licensure or certification is required by law or provided on a voluntary basis. The requirement also applies for those categories of providers that would otherwise be exempt by the state because the provider is working in a non-profit, state-owned or church setting. Licensure/certification is mandatory for a provider to become a CHAMPUS-authorized provider.

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b. Monitoring required. The Director, OCHAMPUS, or a designee, shall develop appropriate monitoring programs and issue guidelines, criteria, or norms necessary to ensure that CHAMPUS expenditures are limited to necessary medical supplies and services at the most reasonable cost to the government and beneficiary. The Director, OCHAMPUS, or a designee, also will take such steps as necessary to deter overutilization of services.

c. Christian Science. Christian Science practitioners and Christian Science nurses are authorized to provide services under CHAMPUS. Inasmuch as they provide services of an extramedical nature, the general criteria outlined above do not apply to Christian Science services (refer to subparagraph C.3.d.(2), below, regarding services of Christian Science practitioners and nurses).

d. Physician referral and supervision. Physician referral and supervision is required for the services of paramedical providers as listed in subparagraph C.3.c.8. and for pastoral counselors, and mental health counselors. Physician referral means that the physician must actually see the patient, perform an evaluation, and arrive at an initial diagnostic impression prior to referring the patient. Documentation is required of the physician's examination, diagnostic impression, and referral. Physician supervision means that the physician provides overall medical management of the case. The physician does not have to be physically located on the premises of the provider to whom the referral is made. Communication back to the referring physician is an indication of medical management.

e. Medical records: Individual professional providers must maintain adequate clinical records to substantiate that specific care was actually furnished, was medically necessary, and appropriate, and identify(ies) the individual(s) who provided the care. This applies whether the care is inpatient or outpatient. The minimum requirements for medical record documentation are set forth by the following:

- (1) The cognizant state licensing authority;
- (2) The Joint Commission on Accreditation of Healthcare Organizations, or other health care accreditation organizations as may be appropriate;
- (3) Standards of practice established by national medical organizations; and
- (4) This Regulation.

2. Interns and residents. Interns and residents may not be paid directly by CHAMPUS for services rendered to a beneficiary when their services are provided as part of their employment (either salaried or contractual) by a hospital or other institutional provider.

(a) Psychiatric admission evaluation report within 24 hours of admission.

(b) History and physical examination within 24 hours of admission; complete report documented within 72 hours for acute and residential programs and within 3 working days for partial programs.

(c) Individual and family therapy notes within 24 hours of procedure for acute, detoxification and Residential Treatment Center (RTC) programs and within 48 hours for partial programs.

(d) Preliminary treatment plan within 24 hours of admission.

(e) Master treatment plan within 72 hours of admission for acute care, 10 days for RTC care, 7 days for full-day partial programs and within 5 days for half-day partial programs.

(f) Family assessment report within 72 hours of admission for acute care and 7 days for RTC and partial programs.

(g) Nursing assessment report within 24 hours of admission.

(h) Nursing notes at the end of each shift for acute and detoxification programs; every ten visits for partial hospitalization; and at least once a week for RTCs.

(i) Daily physician notes for intensive treatment, detoxification, and rapid stabilization programs; twice per week for acute programs; and once per week for RTC and partial programs.

(j) Group therapy notes once per week.

(k) Ancillary service notes once per week.

NOTE: A pattern of failure to meet the above criteria may result in provider sanctions prescribed under Chapter 9 of the Regulation.

4. Double coverage information. When the CHAMPUS beneficiary is eligible for medical benefits coverage through another plan, insurance, or program, either private or Government, the following information must be provided:

a. Name of other coverage. Full name and address of double coverage plan, insurance, or program (such as Blue Cross, Medicare, commercial insurance, and state program).

b. Source of double coverage. Source of double coverage (such as employment, including retirement, private purchase, membership in a group, and law).

c. Employer information. If source of double coverage is employment, give name and address of employer.

d. Identification number. Identification number or group number of other coverage.

5. Right to additional information

a. As a condition precedent to the cost-sharing of benefits under this Regulation or pursuant to a review or audit, whether the review or audit is prospective, concurrent, or retroactive, OCHAMPUS or CHAMPUS contractors may request, and shall be entitled to receive, information from a physician or hospital or other person, institution, or organization (including a local, state, or Federal Government agency) providing services or supplies to the beneficiary for whom claims or requests for approval for benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, examination, diagnosis, treatment, or services and supplies furnished to a beneficiary and, as such, shall be necessary for the accurate and efficient administration of CHAMPUS benefits. This may include requests for copies of all medical records or documentation related to the episode of care. In addition, before a determination on a request for preauthorization or claim of benefits is made, a beneficiary, or sponsor, shall provide additional information relevant to the requested determination, when necessary. The recipient of such information shall hold such records confidential except when:

(1) Disclosure of such information is authorized specifically by the beneficiary;

(2) Disclosure is necessary to permit authorized governmental officials to investigate and prosecute criminal actions; or

(3) Disclosure is authorized or required specifically under the terms of DoD Directives 5400.7 and 5400.11, the Freedom of Information Act, and the Privacy Act (references (i), (j), and (k)) (refer to section M. of Chapter 1 of this Regulation).

b. For the purposes of determining the applicability of and implementing the provisions of Chapters 8 and 9, or any provision of similar purpose of any other medical benefits coverage or entitlement, OCHAMPUS or CHAMPUS fiscal intermediaries, without consent or notice to any beneficiary or sponsor, may release to or obtain from any insurance company or other organization, governmental agency, provider, or person, any information with respect to any beneficiary when such release constitutes a routine use duly published in the Federal Register in accordance with the Privacy Act.

c. Before a beneficiary's claim of benefits is adjudicated, the beneficiary or the provider(s) must furnish to CHAMPUS that information which is necessary to make the benefit determination. Failure to provide the requested

information will result in denial of the claim. A beneficiary, by submitting a CHAMPUS claim(s) (either a participating or nonparticipating claim), is deemed to have given consent to the release of any and all medical records or documentation pertaining to the claims and the episode of care.

C. SIGNATURE ON CHAMPUS CLAIM FORM

1. Beneficiary signature. CHAMPUS claim forms must be signed by the beneficiary except under the conditions identified in paragraph C.1.e., below. The parent or guardian may sign for any beneficiary under 18 years.

a. Certification of identity. This signature certifies that the patient identification information provided is correct.

b. Certification of medical care provided. This signature certifies that the specific medical care for which benefits are being claimed actually were rendered to the beneficiary on the dates indicated.

c. Authorization to obtain or release information. Before requesting additional information necessary to process a claim or releasing medical information, the signature of the beneficiary who is 18 years old or older must be recorded on or obtained on the CHAMPUS claim form or on a separate release form. The signature of the beneficiary, parent, or guardian will be requested when the beneficiary is under 18 years.

NOTE: If the care was rendered to a minor and a custodial parent or legal guardian requests information prior to the minor turning 18 years of age, medical records may still be released pursuant to the signature of the parent or guardian, and claims information may still be released to the parent or guardian in response to the request, even though the beneficiary has turned 18 between the time of the request and the response. However, any follow-up request or subsequent request from the parent or guardian, after the beneficiary turns 18 years of age, will necessitate the authorization of the beneficiary (or the beneficiary's legal guardian as appointed by a cognizant court), before records and information can be released to the parent or guardian.

d. Certification of accuracy and authorization to release double coverage information. This signature certifies to the accuracy of the double coverage information and authorizes the release of any information related to double coverage. (Refer to Chapter 8 of this Regulation.)

e. Exceptions to beneficiary signature requirement

(1) Except as required by paragraph C.1.c., above, the signature of a spouse, parent, or guardian will be accepted on a claim submitted for a beneficiary who is 18 years old or older.

(2) When the institutional provider obtains the signature of the beneficiary (or the signature of the parent or guardian when the beneficiary is under 18 years) on a CHAMPUS claim form at admission, the following participating claims may be submitted without the beneficiary's signature.

(a) Claims for laboratory and diagnostic tests and test interpretations from radiologists, pathologists, neurologists, and cardiologists.

(b) Claims from anesthesiologists.

(3) Claims filed by providers using CHAMPUS-approved signature-on-file and claims submission procedures.

2. Provider's signature. A participating provider (see subsection A.8. of Chapter 6) is required to sign the CHAMPUS claim form.

a. Certification. A participating provider's signature on a CHAMPUS claim form:

(1) Certifies that the specific medical care listed on the claim form was, in fact, rendered to the specific beneficiary for which benefits are being claimed, on the specific date or dates indicated, at the level indicated and by the provider signing the claim unless the claim otherwise indicates another individual provided the care. For example, if the claim is signed by a psychiatrist and the care billed was rendered by a psychologist or licensed social worker, the claim must indicate both the name and profession of the individual who rendered the care.

(2) Certifies that the provider has agreed to participate (providing this agreement has been indicated on the claim form) and that the CHAMPUS-determined allowable charge or cost will constitute the full charge or cost for the medical care listed on the specific claim form; and further agrees to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-shared amount paid by, or on behalf of the beneficiary, as full payment for the covered medical services or supplies.

(a) Thus, neither CHAMPUS nor the sponsor is responsible for any additional charges, whether or not the CHAMPUS-determined charge or cost is less than the billed amount.

(b) Any provider who signs and submits a CHAMPUS claim form and then violates this agreement by billing the beneficiary or sponsor for any difference between the CHAMPUS-determined charge or cost and the amount billed is acting in bad faith and is subject to penalties including withdrawal of CHAMPUS approval as a CHAMPUS provider by administrative action of the Director, OCHAMPUS, or a designee, and possible legal action on the part of CHAMPUS, either directly or as a part of a beneficiary action, to recover monies improperly obtained from CHAMPUS beneficiaries or sponsors (refer to Chapter 6 of this Regulation).

b. Physician or other authorized individual professional provider. A physician or other authorized individual professional provider is liable for any signature submitted on his or her behalf. Further, a facsimile signature is not acceptable unless such facsimile signature is on file with, and has been authorized specifically by, the CHAMPUS fiscal intermediary serving the state where the physician or other authorized individual professional provider practices.

c. Hospital or other authorized institutional provider. The provider signature on a claim form for institutional services must be that of an authorized representative of the hospital or other authorized institutional provider, whose signature is on file with and approved by the appropriate CHAMPUS fiscal intermediary.

D. CLAIMS FILING DEADLINE

To be considered for benefits, all claims submitted under CHAMPUS must be filed with the appropriate CHAMPUS fiscal intermediary no later than December 31 of the calendar year immediately following the one in which the covered service or supply was rendered. Failure to file a claim timely waives automatically all rights to any benefits for such services or supplies provided during the period affected by the claims filing deadline.

1. Claims returned for additional information. When a claim initially is submitted within the claims filing time limit, but is returned in whole or in part for additional information to be considered for benefits, the returned claim, along with the requested information, must be resubmitted and received by the appropriate CHAMPUS fiscal intermediary no later than the applicable December 31 deadline or 90 days from the date the claim was returned to the beneficiary, whichever is later.

2. Exception to claims filing deadline. The Director, OCHAMPUS, or a designee, may grant exceptions to the claims filing deadline requirements.

a. Types of exception

(1) Retroactive eligibility. Retroactive CHAMPUS eligibility determinations.

(2) Administrative error. Administrative error (that is, misrepresentation, mistake, or other accountable action) of an officer or employee of OCHAMPUS (including OCHAMPUSEUR) or a CHAMPUS fiscal intermediary, performing functions under CHAMPUS and acting within the scope of that official's authority.

(3) Mental incompetency. Mental incompetency of the beneficiary or guardian or sponsor, in the case of a minor child (which includes inability to communicate, even if it is the result of a physical disability).

(4) Provider billings. Direct billings by participating providers.

(5) Delays by other health insurance. When not attributable to the beneficiary, delays in adjudication by other health insurance companies when double coverage coordination is required before the CHAMPUS benefit determination.

b. Request for exception to claims filing deadline. Beneficiaries who wish to request an exception to the claims filing deadline may submit such a request to the CHAMPUS fiscal intermediary having jurisdiction over the location in which the service was rendered, or as otherwise designated by the Director, OCHAMPUS.

(1) Such requests for an exception must include a complete explanation of the circumstances of the late filing, together with all available documentation supporting the request, and the specific claim denied for late filing.

(2) Each request for an exception to the claims filing deadline is reviewed individually and considered on its own merits.

E. OTHER CLAIMS FILING REQUIREMENTS

Notwithstanding the claims filing deadline described in section D. of this chapter, to lessen any potential adverse impact on a CHAMPUS beneficiary or sponsor that could result from a retroactive denial, the following additional claims filing procedures are recommended or required.

1. Continuing care. Except for claims subject to the CHAMPUS DRG-based payment system, whenever medical services and supplies are being rendered on a continuing basis, an appropriate claim or claims should be submitted every 30 days (monthly) whether submitted directly by the beneficiary or sponsor or by the provider on behalf of the beneficiary. Such claims may be submitted more frequently if the beneficiary or provider so elects. The Director, OCHAMPUS, or a designee, also may require more frequent claims submission based on dollars. Examples of care that may be rendered on a continuing basis are outpatient physical therapy, private duty (special) nursing, or inpatient stays. For claims subject to the CHAMPUS DRG-based payment system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

2. Inpatient mental health services. Under most circumstances, the 60-day inpatient mental health limit applies to the first 60 days of care paid in a calendar year. The patient will be notified when the first 30 days of inpatient mental health benefits have been paid. The beneficiary is responsible for assuring that all claims for care are submitted sequentially and on a regular basis. Once payment has been made for care determined to be medically appropriate and a program benefit, the decision will not be reopened solely on the basis that previous inpatient mental health care had been rendered but not yet billed during the same calendar year by a different provider.

3. Claims involving the services of marriage and family counselors, pastoral counselors, and mental health counselors. CHAMPUS requires that marriage and family counselors, pastoral counselors, and mental health counselors make a written report to the referring physician concerning the CHAMPUS beneficiary's progress. Therefore, each claim for reimbursement for services of marriage and family counselors, pastoral counselors, and mental health counselors must include certification to the effect that a written communication has been made or will be made to the referring physician at the end of treatment, or more frequently, as required by the referring physician.

F. PREAUTHORIZATION

When specifically required in other chapters of this Regulation, preauthorization requires the following:

1. Preauthorization must be granted before benefits can be extended. In those situations requiring preauthorization, the request for such preauthorization shall be submitted and approved before benefits may be extended, except as provided in Chapter 4, subsection A.11. If a claim for services or supplies is submitted without the required preauthorization, no benefits shall be paid, unless the Director, OCHAMPUS, or a designee, has granted an exception to the requirement for preauthorization.

a. Specifically preauthorized services. An approved preauthorization specifies the exact services or supplies for which authorization is being given. In a preauthorization situation, benefits cannot be extended for services or supplies provided beyond the specific authorization.

b. Time limit on preauthorization. Approved preauthorizations are valid for specific periods of time, usually 90 days. If the preauthorized services or supplies are not obtained or commenced within the specified time limit, a new preauthorization is required before benefits may be extended.

2. Treatment plan, management plan. Each preauthorization request shall be accompanied by a proposed medical treatment plan (for inpatient stays under the Basic Program) or management plan (for services under the PFTH) which shall include generally a diagnosis; a detailed summary of complete history and physical; a detailed statement of the problem; the proposed type and extent of treatment or therapy; the proposed treatment modality, including anticipated length of time the proposed modality will be required; any available test results; consultant's reports; and the prognosis. When the preauthorization request involves transfer from a hospital to another inpatient facility, medical records related to the inpatient stay also must be provided.

3. Durable equipment. Requests for preauthorization to purchase durable equipment under the PFTH must list all items of durable equipment previously authorized under the PFTH and state whether the current item of equipment is the initial purchase or a replacement. If it is a replacement item, the date the initial item was purchased also shall be provided.

4. Claims for services and supplies that have been preauthorized. Whenever a claim is submitted for benefits under CHAMPUS involving preauthorized services and supplies, the date of the approved preauthorization must be indicated on the claim form and a copy of the written preauthorization must be attached to the appropriate CHAMPUS claim.

G. CLAIMS REVIEW

It is the responsibility of the CHAMPUS fiscal intermediary (or OCHAMPUS, including OCHAMPUSEUR) to review each CHAMPUS claim submitted for benefit consideration to ensure compliance with all applicable definitions, conditions, limitations, or exclusions specified or enumerated in this Regulation. It is also required that before any CHAMPUS benefits may be extended, claims for medical services and supplies will be subject to utilization review and quality assurance standards, norms, and criteria issued by the Director, OCHAMPUS, or a designee (see paragraph A.1.e. of Chapter 14 for review standards for claims subject to the CHAMPUS DRG-based payment system).

H. BENEFIT PAYMENTS

CHAMPUS benefit payments are made either directly to the beneficiary or sponsor or to the provider, depending on the manner in which the CHAMPUS claim is submitted.

1. Benefit payments made to beneficiary or sponsor. When the CHAMPUS beneficiary or sponsor signs and submits a specific claim form directly to the appropriate CHAMPUS fiscal intermediary (or OCHAMPUS, including OCHAMPUSEUR), any CHAMPUS benefit payments due as a result of that specific claim submission will be made in the name of, and mailed to, the beneficiary or sponsor. In such circumstances, the beneficiary or sponsor is responsible to the provider for any amounts billed.

2. Benefit payments made to participating provider. When the authorized provider elects to participate by signing a CHAMPUS claim form, indicating participation in the appropriate space on the claim form, and submitting a specific claim on behalf of the beneficiary to the appropriate CHAMPUS fiscal intermediary, any CHAMPUS benefit payments due as a result of that claim submission will be made in the name of and mailed to the participating provider. Thus, by signing the claim form, the authorized provider agrees to abide by the CHAMPUS-determined allowable charge or cost, whether or not lower than the amount billed. Therefore, the beneficiary or sponsor is responsible only for any required deductible amount and any cost-sharing portion of the CHAMPUS-determined allowable charge or cost as may be required under the terms and conditions set forth in Chapters 4 and 5 of this Regulation.

3. CEOB. When a CHAMPUS claim is adjudicated, a CEOB is sent to the beneficiary or sponsor. A copy of the CEOB also is sent to the provider if the claim was submitted on a participating basis. The CEOB form provides, at a minimum, the following information:

- a. Name and address of beneficiary.
- b. Name and address of provider.
- c. Services or supplies covered by claim for which CEOB applies.
- d. Dates services or supplies provided.
- e. Amount billed; CHAMPUS-determined allowable charge or cost; and amount of CHAMPUS payment.
- f. To whom payment, if any, was made.
- g. Reasons for any denial.
- h. Recourse available to beneficiary for review of claim decision (refer to Chapter 10 of this Regulation).

NOTE: The Director, OCHAMPUS, or a designee, may authorize a CHAMPUS fiscal intermediary to waive a CEOB to protect the privacy of a CHAMPUS beneficiary.

4. Benefit under \$1. If the CHAMPUS benefit is determined to be under \$1, payment is waived.

I. ERRONEOUS PAYMENTS AND RECOUPMENT

1. Erroneous payments. Erroneous payments are expenditures of government funds that are not authorized by law or the Regulation. Such payments are to be recouped under the provisions of Chapter 11 of this Regulation.

2. Claims denials resulting from clarification or change in law or Regulation. In those instances where claims review results in a finding of denial of benefits previously allowed but currently denied due to a clarification or interpretation of law or this Regulation, or due to a change in this Regulation, no recoupment action need be taken to recover funds expended prior to the effective date of such clarification, interpretation, or change.

3. Fraudulent billing. Claims that are submitted to CHAMPUS that include a billing for services, supplies, or equipment not furnished, or used by, CHAMPUS beneficiaries will be denied in their entirety, regardless of the relative amount of the fraudulent billing compared to the total billings. Claims that have been CHAMPUS cost-shared that are retroactively audited or reviewed and are found to include fraudulent billings may be denied in part or in total based on the discretion of the Director, OCHAMPUS, or a designee.

J. GENERAL ASSIGNMENT OF BENEFITS NOT RECOGNIZED

CHAMPUS does not recognize any general assignment of CHAMPUS benefits to another person. All CHAMPUS benefits are payable as described in this and other chapters of this Regulation.

CHAPTER 10
APPEAL AND HEARING PROCEDURES

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CHAPTER 10
APPEAL AND HEARING PROCEDURES

A. GENERAL

This chapter sets forth the policies and procedures for appealing decisions made by OCHAMPUS, OCHAMPUSEUR, and CHAMPUS contractors adversely affecting the rights and liabilities of CHAMPUS beneficiaries, CHAMPUS participating providers, and providers denied the status of authorized provider under CHAMPUS. An appeal under CHAMPUS is an administrative review of program determinations made under the provisions of law and regulation. An appeal cannot challenge the propriety, equity, or legality of any provision of law or regulation.

1. Initial determination

a. Notice of initial determination and right to appeal

(1) OCHAMPUS, OCHAMPUSEUR, and CHAMPUS contractors shall mail notices of initial determinations to the affected provider or CHAMPUS beneficiary (or representative) at the last known address. For beneficiaries who are under 18 years of age or who are incompetent, a notice issued to the parent, guardian, or other representative, under established CHAMPUS procedures, constitutes notice to the beneficiary.

(2) CHAMPUS contractors and OCHAMPUSEUR shall notify a provider of an initial determination on a claim only if the provider participated in the claim. (See Chapter 7 of this Regulation.)

(3) CHAMPUS peer review organizations shall notify providers and fiscal intermediaries of a denial determination on a claim.

(4) Notice of an initial determination on a claim processed by a CHAMPUS contractor or OCHAMPUSEUR normally will be made on a CHAMPUS Explanation of Benefits (CEOB) form.

(5) Each notice of an initial determination on a request for benefit authorization, a request by a provider for approval as an authorized CHAMPUS provider, or a decision to disqualify or exclude a provider as an authorized provider under CHAMPUS shall state the reason for the determination and the underlying facts supporting the determination.

(6) In any case when the initial determination is adverse to the beneficiary or participating provider, or to the provider seeking approval as an authorized CHAMPUS provider, the notice shall include a statement of the beneficiary's or provider's right to appeal the determination. The procedure for filing the appeal also shall be explained.

b. Effect of initial determination. The initial determination is final unless appealed in accordance with this chapter, or unless the initial determination is reopened by OCHAMPUS, the CHAMPUS contractor, or the CHAMPUS peer review organization.

2. Participation in an appeal. Participation in an appeal is limited to any party to the initial determination, including CHAMPUS, and authorized representatives of the parties. Any party to the initial determination, except CHAMPUS, may appeal an adverse determination. The appealing party is the party who actually files the appeal.

a. Parties to the initial determination. For purposes of the CHAMPUS appeals and hearing procedures, the following are not parties to an initial determination and are not entitled to administrative review under this chapter.

(1) A provider disqualified or excluded as an authorized provider under CHAMPUS based on a determination of abuse or fraudulent practices or procedures under another Federal or federally funded program is not a party to the CHAMPUS action and may not appeal under this chapter.

(2) A beneficiary who has an interest in receiving care or has received care from a particular provider cannot be an appealing party regarding the exclusion, suspension, or termination of the provider under Chapter 9 of this Regulation.

(3) A sponsor or parent of a beneficiary under 18 years of age or guardian of an incompetent beneficiary is not a party to the initial determination and may not serve as the appealing party, although such persons may represent the appealing party in an appeal.

(4) A third party, such as an insurance company, is not a party to the initial determination and is not entitled to appeal even though it may have an indirect interest in the initial determination.

(5) A nonparticipating provider is not a party to the initial determination and may not appeal.

b. Representative. Any party to the initial determination may appoint a representative to act on behalf of the party in connection with an appeal. Generally, the parent of a minor beneficiary and the legally appointed guardian of an incompetent beneficiary shall be presumed to have been appointed representative without specific designation by the beneficiary. The custodial parent or legal guardian (appointed by a cognizant court) of a minor beneficiary may initiate an appeal based on the above presumption. However, should a minor beneficiary turn 18 years of age during the course of an appeal, then any further requests to appeal on behalf of the beneficiary must be from the beneficiary or pursuant to the written authorization of the beneficiary appointing a representative. For example, if the beneficiary is 17 years of age and the sponsor (who is a custodial parent) requests a formal review, absent written objection by the minor beneficiary, the sponsor is presumed to be acting on behalf of the minor beneficiary. Following the issuance of the formal review, the sponsor requests a hearing; however if, at the time of the request for a hearing, the beneficiary is 18 years of age or older, the request must either be by the beneficiary or the beneficiary must appoint a representative. The sponsor, in this example, could not pursue the request for hearing without being appointed by the beneficiary as the beneficiary's representative.

(1) The representative shall have the same authority as the party to the appeal and notice given to the representative shall constitute notice required to be given to the party under this Regulation.

(2) To avoid possible conflicts of interest, an officer or employee of the United States, such as an employee or member of a Uniformed Service, including an employee or staff member of a Uniformed Service legal office, or a CHAMPUS advisor, subject to the exceptions in 18 U.S.C. 205 (reference (hh)), is not eligible to serve as a representative. An exception usually is made for an employee or member of a Uniformed Service who represents an immediate family member. In addition, the Director, OCHAMPUS, or designee, may appoint an officer or employee of the United States as the CHAMPUS representative at a hearing.

3. Burden of proof. The burden of proof is on the appealing party to establish affirmatively by substantial evidence the appealing party's entitlement under law and this Regulation to the authorization of CHAMPUS benefits, approval of authorized CHAMPUS provider status, or removal of sanctions imposed under Chapter 9 of this Regulation. If a presumption

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(c) Has had a minimum of 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting, as determined by the Director, OCHAMPUS, or a designee.

NOTE: Patients' organic medical problems must receive appropriate concurrent management by a physician.

(7) Certified psychiatric nurse specialist. A certified psychiatric nurse specialist may provide covered care independent of physician referral and supervision. For purposes of CHAMPUS, a certified psychiatric nurse specialist is an individual who:

(a) Is a licensed, registered nurse; and

(b) Has at least a master's degree in nursing from a regionally accredited institution with a specialization in psychiatric and mental health nursing; and

(c) Has had at least 2 years of post-master's degree practice in the field of psychiatric and mental health nursing, including an average of 8 hours of direct patient contact per week; or

(d) Is listed in a CHAMPUS-recognized, professionally sanctioned listing of clinical specialists in psychiatric and mental health nursing.

(8) Certified physician assistant. A physician assistant may provide care under general supervision of a physician (see Chapter 14 G.I.C. for limitations on reimbursement). For purposes of CHAMPUS, a physician assistant must meet the applicable state requirements governing the qualifications of physician assistants and at least one of the following conditions:

(a) Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians, or

(b) Has satisfactorily completed a program for preparing physician assistants that:

1 Was at least 1 academic year in length;

2 Consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and

3 Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or

(c) Has satisfactorily completed a formal educational program for preparing physician assistants that does not meet the requirements of subparagraph (1)(b) of this paragraph and had been assisting primary care physicians for a minimum of 12 months during the 18-month period immediately preceding January 1, 1987.

(9) Other individual paramedical providers. The services of the following individual professional providers of care to be considered for benefits on a fee-for-service basis may be provided only if the beneficiary is referred by a physician for the treatment of a medically-diagnosed condition and a physician must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by these individual paramedical providers.

- (a) Licensed registered nurses.
- (b) Licensed practical or vocational nurses.
- (c) Licensed registered physical therapists.
- (d) Audiologists.
- (e) Speech therapists (speech pathologists).

d. Extramedical individual providers. Extramedical individual providers are those who do counseling or nonmedical therapy and whose training and therapeutic concepts are outside the medical field.

(1) Marriage and family counselors, pastoral counselors, and mental health counselors. The services of certain extramedical marriage and family counselors, pastoral counselors, and mental health counselors are coverable on a fee-for-service basis, under the following specified conditions:

- (a) The CHAMPUS beneficiary must be referred for therapy by a physician.
- (b) A physician is providing ongoing oversight and supervision of the therapy being provided.
- (c) The marriage and family counselor, pastoral counselor, and mental health counselor must certify on each claim for reimbursement that a written communication has been made or will be made to the referring physician of the results of the treatment. Such communication will be made at the end of the treatment, or more frequently, as required by the referring physician (refer to chapter 7).
- (d) Marriage and family counselors and pastoral counselors shall have the following:

1 Recognized graduate professional education with the minimum of an earned master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline.

2 The following experience:

a Either 200 hours of approved supervision in the practice of marriage and family counseling or pastoral counseling, ordinarily to be completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases, and

b 1,000 hours of clinical experience in the practice of marriage and family counseling or pastoral counseling under approved supervision, involving at least 50 different cases; or

c 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling or pastoral counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years, and

d 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in marriage and family counseling or pastoral counseling under approved supervision, involving at least 20 cases, and

(e) Mental health counselors shall have the following:

1 Minimum of a master's degree in mental health counseling or allied mental health field from a regionally accredited institution, and

2 Two years of post-master's experience which includes 3000 hours of clinical work and 100 hours of face-to-face supervision.

(f) These providers must also be licensed or certified to practice as a marriage and family counselor, pastoral counselor or mental health counselor by the jurisdiction where practicing. If specific licensure is not available in the state, then licensure under general provisions, where available, is required. If the jurisdiction does not provide for licensure or certification either in a specific or general counselor category, the provider must be certified by or eligible for full clinical membership in the appropriate national professional association that sets standards for the specific profession.

(g) Grace period for counselors in states where licensure/certification is optional. CHAMPUS is providing a grace period for those counselors who did not obtain optional licensure/certification in their jurisdiction, not realizing it was a CHAMPUS requirement for authorization. The exemption by state law for pastoral counselors may have misled this group into thinking licensure was not required. The same situation may have occurred with the other counselor categories where licensure was either not mandated by the state or was provided under a more general category such as "professional counselors." This grace period only pertains to the licensure/certification requirement, applies only to counselors who are already approved as of October 29, 1990, and only in those areas where the licensure/certification is optional. Any counselor who is not licensed/certified in the state in which he/she is practicing by August 1, 1991, will be terminated under the provisions of Chapter 9 of this Regulation. This grace period does not change any of the other existing requirements which remain in effect. During this grace period, membership or proof of eligibility for full clinical membership in a recognized professional association is required for those counselors who are not licensed or certified by the state. The following organizations are recognized for counselors at the level indicated: full clinical member of the American Association of Marriage and Family Counselors; membership at the fellow or diplomate level of the American Association of Pastoral Counselors; and membership in the National Academy of Certified Clinical Mental Health Counselors. Acceptable proof of eligibility for membership is a letter from the appropriate certifying organization. This opportunity for delayed certification/licensure is limited to the counselor category only as the language in all of the other provider categories has been consistent and unmodified from the time each of the other provider categories were added. The grace period does not apply in those states where licensure is mandatory.

(2) Christian Science practitioners and Christian Science nurses. CHAMPUS cost shares the services of Christian Science practitioners and nurses. In order to bill as such, practitioners or nurses must be listed or be eligible for listing in the Christian Science Journal at the time the service is provided.

D. OTHER PROVIDERS

Certain medical supplies and services of an ancillary or supplemental nature are coverable by CHAMPUS, subject to certain controls. This category of provider includes the following:

1. Independent laboratory. Laboratory services of independent laboratories may be cost-shared if the laboratory is approved for participation under Medicare and certified by the Medicare Bureau, Health Care Financing Administration.

2. Suppliers of portable x-ray services. Such suppliers must meet the conditions of coverage of the Medicare program, set forth in the Medicare regulations (reference (h)), or the Medicaid program in that state in which the covered service is provided.

3. Pharmacies. Pharmacies must meet the applicable requirements of state law in the state in which the pharmacy is located.

4. Ambulance companies. Such companies must meet the requirements of state and local laws in the jurisdiction in which the ambulance firm is licensed.

5. Medical equipment firms, medical supply firms. As determined by the Director, OCHAMPUS, or a designee.

E. IMPLEMENTING INSTRUCTIONS

The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this chapter.

F. EXCLUSION

Regardless of any provision in this chapter, a provider who is suspended, excluded, or terminated under Chapter 9 of this Regulation is specifically excluded as an authorized CHAMPUS provider.

CHAPTER 7
CLAIMS SUBMISSION, REVIEW, AND PAYMENT

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CHAPTER 7
CLAIMS SUBMISSION, REVIEW, AND PAYMENT

A. GENERAL

The Director, OCHAMPUS, or a designee, is responsible for ensuring that benefits under CHAMPUS are paid only to the extent described in this Regulation. Before benefits can be paid, an appropriate claim must be submitted that includes sufficient information as to beneficiary identification, the medical services and supplies provided, and double coverage information, to permit proper, accurate, and timely adjudication of the claim by the CHAMPUS contractor or OCHAMPUS. Providers must be able to document that the care or service shown on the claim was rendered. This section sets forth minimum medical record requirements for verification of services. Subject to such definitions, conditions, limitations, exclusions, and requirements as may be set forth in this Regulation, the following are the CHAMPUS claim filing requirements:

1. CHAMPUS identification card required. A patient shall present his or her applicable CHAMPUS identification card (that is, Uniformed Services identification card) to the authorized provider of care that identifies the patient as an eligible CHAMPUS beneficiary (refer to Chapter 3 of this Regulation).

2. Claim required. No benefit may be extended under the Basic Program or PFTH without the submission of a complete and properly executed appropriate claim form.

3. Responsibility for perfecting claim. It is the responsibility of the CHAMPUS beneficiary or sponsor or the authorized provider acting on behalf of the CHAMPUS beneficiary to perfect a claim for submission to the appropriate CHAMPUS fiscal intermediary. Neither a CHAMPUS fiscal intermediary nor OCHAMPUS is authorized to prepare a claim on behalf of a CHAMPUS beneficiary.

4. Obtaining appropriate claim form. CHAMPUS provides specific CHAMPUS forms appropriate for making a claim for benefits for various types of medical services and supplies (such as hospital, physician, or prescription drugs). Claim forms may be obtained from the appropriate CHAMPUS fiscal intermediary who processes claims for the beneficiary's state of residence, from the Director, OCHAMPUS, or a designee, or from CHAMPUS health benefits advisors (HBAs) located at all Uniformed Services medical facilities.

5. Prepayment not required. A CHAMPUS beneficiary or sponsor is not required to pay for the medical services or supplies before submitting a claim for benefits.

6. Deductible certificate. If the fiscal year outpatient deductible has been met by a beneficiary (\$50) or a family (\$100 aggregate) through the submission of a claim or claims to a CHAMPUS fiscal intermediary in a geographic location different from the location where a current claim is being submitted,

the beneficiary or sponsor must obtain a deductible certificate from the CHAMPUS fiscal intermediary where the applicable individual or family fiscal year deductible was met. Such deductible certificate must be attached to the current claim being submitted for benefits. Failure to obtain a deductible certificate under such circumstances will result in a second individual or family fiscal year deductible being applied. However, this second deductible may be reimbursed once appropriate documentation, as described in this subsection A.6., is supplied to the CHAMPUS fiscal intermediary applying the second deductible (refer to section F. of Chapter 4 of this Regulation).

7. Nonavailability Statement (DD Form 1251). In some geographic locations or under certain circumstances, it is necessary for a CHAMPUS beneficiary to determine whether the required medical care can be provided through a Uniformed Services facility. If the required medical care cannot be provided by the Uniformed Services facility, a Nonavailability Statement will be issued. When required (except for emergencies), this Nonavailability Statement must be issued before medical care is obtained from civilian sources. Failure to secure such a statement will waive the beneficiary's rights to benefits under CHAMPUS, subject to appeal to the appropriate hospital commander (or higher medical authority).

a. Rules applicable to issuance of Nonavailability Statement. The ASD(HA) has issued DoD Instruction 6015.19 (reference (gg)) that contains rules for the issuance of Nonavailability Statements. Such rules may change depending on the current situations.

b. Beneficiary responsibility. The beneficiary shall ascertain whether or not he or she resides in a geographic area that requires obtaining a Nonavailability Statement. Information concerning current rules may be obtained from the CHAMPUS fiscal intermediary concerned, a CHAMPUS HBA or the Director, OCHAMPUS, or a designee.

c. Rules in effect at time civilian care is provided apply. The applicable rules regarding Nonavailability Statements in effect at the time the civilian care is rendered apply in determining whether a Nonavailability Statement is required.

d. Nonavailability Statement must be filed with applicable claim. When a claim is submitted for CHAMPUS benefits that includes services for which a Nonavailability Statement is required, such statement must be submitted along with the claim form.

B. INFORMATION REQUIRED TO ADJUDICATE A CHAMPUS CLAIM

Claims received that are not completed fully and that do not provide the following minimum information may be returned. If enough space is not available on the appropriate claim form, the required information must be attached separately and include the patient's name and address, be dated, and signed.

1. Patient's identification information. The following patient identification information must be completed on every CHAMPUS claim form submitted for benefits before a claim will be adjudicated and processed:

- a. Patient's full name.
- b. Patient's residence address.
- c. Patient's date of birth.
- d. Patient's relationship to sponsor.

NOTE: If name of patient is different from sponsor, explain (for example, stepchild or illegitimate child).

- e. Patient's identification number (from DD Form 1173).
- f. Patient's identification card effective date and expiration date (from DD Form 1173).
- g. Sponsor's full name.
- h. Sponsor's service or social security number.
- i. Sponsor's grade.
- j. Sponsor's organization and duty station. Home port for ships; home address for retiree.
- k. Sponsor's branch of service or deceased or retiree's former branch of service.

- l. Sponsor's current status. Active duty, retired, or deceased.

2. Patient treatment information. The following patient treatment information routinely is required relative to the medical services and supplies for which a claim for benefits is being made before a claim will be adjudicated and processed:

a. Diagnosis. All applicable diagnoses are required; standard nomenclature is acceptable. In the absence of a diagnosis, a narrative description of the definitive set of symptoms for which the medical care was rendered must be provided.

b. Source of care. Full name of source of care (such as hospital or physician) providing the specific medical services being claimed.

c. Full address of source of care. This address must be where the care actually was provided, not a billing address.

d. Attending physician. Name of attending physician (or other authorized individual professional provider).

e. Referring physician. Name and address of ordering, prescribing, or referring physician.

f. Status of patient. Status of patient at the time the medical services and supplies were rendered (that is, inpatient or outpatient).

g. Dates of service. Specific and inclusive dates of service.

h. Inpatient stay. Source and dates of related inpatient stay (if applicable).

i. Physicians or other authorized individual professional providers. The claims must give the name of the individual actually rendering the care, along with the individual's professional status (e.g., M.D., Ph.D., R.N., etc.) and provider number, if the individual signing the claim is not the provider who actually rendered the service. The following information must also be included:

(1) Date each service was rendered.

(2) Procedure code or narrative description of each procedure or service for each date of service.

(3) Individual charge for each item of service or each supply for each date.

(4) Detailed description of any unusual complicating circumstances related to the medical care provided that the physician or other individual professional provider may choose to submit separately.

j. Hospitals or other authorized institutional providers. For care provided by hospitals (or other authorized institutional providers), the following information also must be provided before a claim will be adjudicated and processed:

(1) An itemized billing showing each item of service or supply provided for each day covered by the claim.

NOTE: The Director, OCHAMPUS, or a designee, may approve, in writing, an alternate billing procedure for RTCs or other special institutions, in which case the itemized billing requirement may be waived. The particular facility will be aware of such approved alternate billing procedure.

(2) Any absences from a hospital or other authorized institution during a period for which inpatient benefits are being claimed must be identified specifically as to date or dates and provide details on the purpose of the absence. Failure to provide such information will result in denial of benefits and, in an ongoing case, termination of benefits for the inpatient stay at least back to the date of the absence.

(3) For hospitals subject to the CHAMPUS DRG-based payment system (see subparagraph A.1.b.(4) of Chapter 14), the following information is also required:

(a) The principal diagnosis (the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital).

(b) All secondary diagnoses.

(c) All procedures performed.

(d) The discharge status of the beneficiary.

(e) The hospital's Medicare provider number.

(f) The source of the admission.

(4) Claims submitted by hospitals (or other authorized institutional providers) must include the name of the individual actually rendering the care, along with the individual's professional status (e.g., M.D., Ph.D., R.N., etc.).

k. Prescription drugs and medicines (and insulin). For prescription drugs and medicines (and insulin, whether or not a prescription is required) receipted bills must be attached and the following additional information provided:

(1) Name of drug.

NOTE: When the physician or pharmacist so requests, the name of the drug may be submitted to the CHAMPUS fiscal intermediary directly by the physician or pharmacist.

(2) Strength of drug.

(3) Name and address of pharmacy where drug was purchased.

(4) Prescription number of drug being claimed.

1. Other authorized providers. For items from other authorized providers (such as medical supplies), an explanation as to the medical need must be attached to the appropriate claim form. For purchases of durable equipment under the PFTH, it is necessary also to attach a copy of the pre-authorization.

m. Nonparticipating providers. When the beneficiary or sponsor submits the claim to the CHAMPUS fiscal intermediary (that is, the provider elects not to participate), an itemized bill from the provider to the beneficiary or sponsor must be attached to the CHAMPUS claim form.

3. Medical records/medical documentation. Medical records are of vital importance in the care and treatment of the patient. Medical records serve as a basis for planning of patient care and for the ongoing evaluation of the patient's treatment and progress. Accurate and timely completion of orders, notes, etc., enable different members of a health care team and subsequent health care providers to have access to relevant data concerning the patient. Appropriate medical records must be maintained in order to accommodate utilization review and to substantiate that billed services were actually rendered.

a. All care rendered and billed must be appropriately documented in writing. Failure to document the care billed will result in the claim or specific services on the claim being denied CHAMPUS cost-sharing.

b. A pattern of failure to adequately document medical care will result in episodes of care being denied CHAMPUS cost-sharing.

c. Cursory notes of a generalized nature that do not identify the specific treatment and the patient's response to the treatment are not acceptable.

d. The documentation of medical records must be legible and prepared as soon as possible after the care is rendered. Entries should be made when the treatment described is given or the observations to be documented are made. The following are documentation requirements and specific time frames for entry into the medical records:

(1) General requirements for acute medical/surgical services:

- (a) Admission evaluation report within 24 hours of admission.
- (b) Completed history and physical examination report within 72 hours of admission.
- (c) Registered nursing notes at the end of each shift.
- (d) Daily physician notes.

(2) Requirements specific to mental health services:

d. Hospitals, psychiatric. A psychiatric hospital is an institution which is engaged primarily in providing services to inpatients for the diagnosis and treatment of mental disorders.

(1) There are two major categories of psychiatric hospitals:

(a) The private psychiatric hospital category includes both proprietary and the not-for-profit nongovernmental institutions.

(b) The second category is those psychiatric hospitals that are controlled, financed, and operated by departments or agencies of the local, state, or Federal Government and always are operated on a not-for-profit basis.

(2) In order for the services of a psychiatric hospital to be covered, the hospital shall comply with the provisions outlined in paragraph B.4.a. of this chapter. All psychiatric hospitals shall be accredited under the JCAHO Accreditation Manual for Hospitals (AMH) standards in order for their services to be cost-shared under CHAMPUS. In the case of those psychiatric hospitals that are not JCAHO-accredited because they have not been in operation a sufficient period of time to be eligible to request an accreditation survey by the JCAHO, the Director, OCHAMPUS, or a designee, may grant temporary approval if the hospital is certified and participating under Title XVIII of the Social Security Act (Medicare, Part A). This temporary approval expires 12 months from the date on which the psychiatric hospital first becomes eligible to request an accreditation survey by the JCAHO.

(3) Factors to be considered in determining whether CHAMPUS will cost-share care provided in a psychiatric hospital include, but are not limited to, the following considerations:

(a) Is the prognosis of the patient such that care provided will lead to resolution or remission of the mental illness to the degree that the patient is of no danger to others, can perform routine daily activities, and can be expected to function reasonably outside the inpatient setting?

(b) Can the services being provided be provided more economically in another facility or on an outpatient basis?

(c) Are the charges reasonable?

(d) Is the care primarily custodial or domiciliary?
(Custodial or domiciliary care of the permanently mentally ill or retarded is not a benefit under the Basic Program.)

(4) Although psychiatric hospitals are accredited under JCAHO AMH standards, their medical records must be maintained in accordance with the JCAHO Consolidated Standard Manual for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities and Facilities Serving the Mentally Retarded, along with the requirements set forth in Section 199.7(b)(3). The hospital is responsible for assuring that patient services and all treatment are accurately documented and completed in a timely manner.

e. Hospitals, long-term (tuberculosis, chronic care, or rehabilitation). To be considered a long-term hospital, an institution for patients that have tuberculosis or chronic diseases must be an institution (or distinct part of an institution) primarily engaged in providing by or under the supervision of a physician appropriate medical or surgical services for the diagnosis and active treatment of the illness or condition in which the institution specializes.

(1) In order for the service of long-term hospitals to be covered, the hospital must comply with the provisions outlined in paragraph B.4.a. of this chapter. In addition, in order for services provided by such hospitals to be coverable by CHAMPUS, they must be primarily for the treatment of the presenting illness.

(2) Custodial or domiciliary care is not coverable under CHAMPUS, even if rendered in an otherwise authorized long-term hospital.

(3) The controlling factor in determining whether a beneficiary's stay in a long-term hospital is coverable by CHAMPUS is the level of professional care, supervision, and skilled nursing care that the beneficiary requires, in addition to the diagnosis, type of condition, or degree of functional limitations. The type and level of medical services required or rendered is controlling for purposes of extending CHAMPUS benefits; not the type of provider or condition of the beneficiary.

f. Skilled nursing facility. A skilled nursing facility is an institution (or a distinct part of an institution) that is engaged primarily in providing to inpatients medically necessary skilled nursing care, which is other than a nursing home or intermediate facility, and which:

(1) Has policies that are developed with the advice of (and with provisions for review on a periodic basis by) a group of professionals, including one or more physicians and one or more registered nurses, to govern the skilled nursing care and related medical services it provides.

(2) Has a physician, a registered nurse, or a medical staff responsible for the execution of such policies.

(3) Has a requirement that the medical care of each patient must be under the supervision of a physician, and provides for having a physician available to furnish necessary medical care in case of an emergency.

(4) Maintains clinical records on all patients.

(5) Provides 24-hour skilled nursing service that is sufficient to meet nursing needs in accordance with the policies developed as provided in subparagraph B.4.f.(1), above, and has at least one registered professional nurse employed full-time.

(6) Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals.

(7) Has in effect a utilization review plan that is operational and functioning.

(8) In the case of an institution in a state in which state or applicable local law provides for the licensing of this type facility, the institution:

(a) Is licensed pursuant to such law, or

(b) Is approved by the agency of such state or locality responsible for licensing such institutions as meeting the standards established for such licensing.

(9) Has in effect an operating plan and budget.

(10) Meets such provisions of the most current edition of the Life Safety Code (reference (dd)) as are applicable to nursing facilities; except that if the Secretary of Health and Human Services has waived, for such periods, as deemed appropriate, specific provisions of such code which, if rigidly applied, would result in unreasonable hardship upon a nursing facility.

g. Residential treatment centers. A residential treatment center (RTC) is a facility, or distinct part of a facility, that provides to children and adolescents under the age of 21, a total, 24-hour therapeutically planned group living and learning situation where distinct and individualized psychotherapeutic interventions can take place. Residential treatment is a specific level of care to be differentiated from acute, intermediate and long-term hospital care, where the least restrictive environment is maintained to allow for normalization of the patient's surroundings. The RTC must be both physically and programmatically distinct if it is a part or subunit of a larger treatment program. An RTC is organized and professionally staffed to provide residential treatment of mental disorders to children and adolescents who have sufficient intellectual potential to respond to active treatment (that is, for whom medical opinion or

medical evidence can reasonably conclude that treatment of the mental disorder will result in an improved ability to function outside the RTC), for whom outpatient, partial hospitalization or other level of inpatient treatment is not appropriate, and for whom a protected and structured environment is medically or psychologically necessary.

(1) In order for the services of an RTC to be authorized, the RTC shall:

(a) Be accredited by the Joint Commission on Accreditation of Healthcare Organizations under the Consolidated Standards Manual for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities and Facilities Serving the Mentally Retarded;

(b) Comply with the CHAMPUS Standards for Residential Treatment Centers Serving Children and Adolescents with Mental Disorders, as issued by the Director, OCHAMPUS;

(c) Have entered into a Participation Agreement with OCHAMPUS within which the RTC agrees, in part, to:

1 Render residential treatment center inpatient services to eligible CHAMPUS beneficiaries in need of such services, in accordance with the participation agreement and the CHAMPUS regulation;

2 Accept payment for its services based upon the methodology provided in Chapter 14, paragraph E, or such other method as determined by the Director, OCHAMPUS;

3 Accept the CHAMPUS all-inclusive per diem rate as payment in full and collect from the CHAMPUS beneficiary or the family of the CHAMPUS beneficiary only those amounts that represent the beneficiary's liability, as defined in Chapter 4, and charges for services and supplies that are not a benefit of CHAMPUS;

4 Make all reasonable efforts acceptable to the Director, OCHAMPUS, to collect those amounts which represent the beneficiary's liability, as defined in Chapter 4;

5 Comply with the provisions of Chapter 8, and submit claims first to all health insurance coverage to which the beneficiary is entitled that is primary to CHAMPUS;

6 Submit claims for services provided to CHAMPUS beneficiaries at least every 30 days. If claims are not submitted at least every 30 days, the RTC agrees not to bill the beneficiary or the beneficiary's family any amounts disallowed by CHAMPUS;

7 Designate an individual who will act as liaison for CHAMPUS inquiries. The RTC shall inform OCHAMPUS in writing of the designated individual;

8 Furnish OCHAMPUS with cost data certified to by an independent accounting firm or other agency as authorized by the Director, OCHAMPUS;

9 Grant the Director, OCHAMPUS, or designee, the right to conduct quality assurance audits or accounting audits with full access to patients and records to determine the quality and cost-effectiveness of care rendered. The audits may be conducted on a scheduled or unscheduled (unannounced) basis. This right to audit/review includes, but is not limited to:

a Examination of fiscal and all other records of the RTC which would confirm compliance with the participation agreement and designation as an authorized CHAMPUS RTC provider;

b Conducting such audits of RTC records including clinical, financial, and census records, as may be necessary to determine the nature of the services being provided, and the basis for charges and claims against the United States for services provided CHAMPUS beneficiaries;

c Examining reports of evaluations and inspections conducted by federal, state and local government, and private agencies and organizations;

d Conducting on-site inspections of the facilities of the RTC and interviewing employees, members of the staff, contractors, board members, volunteers, and patients, as required;

e Audits conducted by the United States General Accounting Office.

(d) Be licensed and operational for a minimum period of six months.

(2) The RTC shall not be considered to be a CHAMPUS-authorized provider and CHAMPUS benefits shall not be paid for services provided by the RTC until the date the participation agreement is signed by the Director, OCHAMPUS, or a designee.

(3) Even though an RTC may qualify as a CHAMPUS-authorized provider and may have entered into a participation agreement with CHAMPUS, payment by CHAMPUS for a particular admission is contingent upon certain conditions:

(a) The child seeking admission is suffering from a mental disorder which meets the diagnostic criteria of the DSM-III and meets the CHAMPUS definition of a mental disorder in Chapter 2.

- (b) The child meets the criteria for admission to an RTC issued by the Director, OCHAMPUS.
- (c) A psychiatrist or other physician or a clinical psychologist shall recommend that the child be admitted to the RTC.
- (d) A psychiatrist or a clinical psychologist shall direct the development of the child's treatment plan.
- (e) All services shall be provided by or under the supervision of a qualified mental health provider (refer to paragraph C.3.i. of Chapter 4).
- (f) The child's admission to the RTC is authorized by CHAMPUS, or a designee.

(4) Under the terms of the participation agreement, RTCs must provide the following safeguards for continued benefit access and quality of care:

- (a) Assure that any and all eligible beneficiaries receive care which complies with standards in paragraphs B.4.g.(1)(a) through (d) and B.4.g.(3);
- (b) Provide inpatient services to CHAMPUS beneficiaries in the same manner it provides inpatient services to all other patients;
- (c) Not discriminate against CHAMPUS beneficiaries in any manner, including admission practices, placement in special or separate wings or rooms, or provisions of special or limited treatment.

(5) At a minimum, medical records will be maintained in accordance with the JCAHO Consolidated Standard Manual for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities and Facilities Serving the Mentally Retarded, along with the requirements set forth in Section 199.7(b)(3). The residential treatment center is responsible for assuring that patient services and all treatment are accurately documented and completed in a timely manner.

h. Christian Science sanatoriums. The services obtained in Christian Science sanatoriums are covered by CHAMPUS as inpatient care. To qualify for coverage, the sanatorium either must be operated by, or be listed and certified by the First Church of Christ, Scientist.

i. Infirmaries. Infirmaries are facilities operated by student health departments of colleges and universities to provide inpatient or outpatient care to enrolled students. Charges for care provided by such facilities will not be cost-shared by CHAMPUS if the student would not be charged in the absence of CHAMPUS, or if student is covered by a mandatory student health insurance plan, in which enrollment is required as a part of the student's school registration and the charges by the college or university include a premium for the student health insurance coverage. CHAMPUS will cost-share only if enrollment in the student health program or health insurance plan is voluntary.

NOTE: An infirmary in a boarding school also may qualify under this provision, subject to review and approval by the Director, OCHAMPUS, or a designee.

j. Other STFs

(1) General

(a) Care provided by certain STFs (on either an inpatient or outpatient basis), other than those listed above, may be cost-shared by CHAMPUS under specified circumstances.

1 The course of treatment is prescribed by a doctor of medicine or osteopathy.

2 The patient is under the supervision of a physician during the entire course of the inpatient admission or the outpatient treatment.

3 The type and level of care and service rendered by the institution are otherwise authorized by this Regulation.

4 The facility meets all licensing or other certification requirements that are extant in the jurisdiction in which the facility is located geographically.

5 Is other than a nursing home, intermediate care facility, home for the aged, halfway house, or other similar institution.

6 Is accredited by the JCAHO or other CHAMPUS-approved accreditation organization, if an appropriate accreditation program for the given type of facility is available. As future accreditation programs are developed to cover emerging specialized treatment programs, such accreditation will be a prerequisite to coverage by CHAMPUS for services provided by such facilities.

(b) To ensure that CHAMPUS beneficiaries are provided quality care at a reasonable cost when treated by a STF, the Director, OCHAMPUS, or a designee, will retain the right to:

1 Require prior approval of all admissions to specialized inpatient treatment facilities.

2 Set appropriate standards for STFs in addition to or in the absence of JCAHO accreditation.

3 Monitor facility operations and treatment programs on a continuing basis and conduct onsite inspections on a scheduled and unscheduled basis.

4 Negotiate agreements of participation.

5 Terminate approval of a case when it is ascertained that a departure from the facts upon which the admission was based originally has occurred.

6 Declare an STF not eligible for CHAMPUS payment if that facility has been found to have engaged in fraudulent or deceptive practices.

(c) In general, the following disclaimers apply to treatment by STFs:

1 Just because one period or episode of treatment by a facility has been covered by CHAMPUS may not be construed to mean that later episodes of care by the same or similar facility will be covered automatically.

2 The fact that one case has been authorized for treatment by a specific facility or similar type of facility may not be construed to mean that similar cases or later periods of treatment will be extended CHAMPUS benefits automatically.

(2) Types of providers. The following is a list of facilities that have been designated specifically as STFs.

(a) Free-standing ambulatory surgical centers. Care provided by freestanding ambulatory surgical centers may be cost-shared by CHAMPUS under the following circumstances:

1 The treatment is prescribed and supervised by a physician.

2 The type and level of care and services rendered by the center are otherwise authorized by this Regulation.

3 The center meets all licensing or other certification requirements of the jurisdiction in which the facility is located.

4 The center is accredited by the JCAHO, the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), or such other standards as authorized by the Director, OCHAMPUS.

5 A childbirth procedure provided by a CHAMPUS-approved free-standing ambulatory surgical center shall not be cost-shared by CHAMPUS unless the surgical center is also a CHAMPUS-approved birthing center institutional provider as established by the birthing center provider certification requirement of this Regulation.

(b) PFTH facilities. STFs also include facilities that seek approval to provide care authorized under the PFTH. (Refer to Chapter 5 of this Regulation.)

(c) Substance use disorder rehabilitation facilities. In order to be authorized under CHAMPUS as a provider of substance use detoxification, rehabilitative services, outpatient treatment, and family therapy, substance use rehabilitation facilities, both freestanding facilities and hospital-based facilities, shall operate primarily for the purpose of providing treatment of substance use disorders (on either an inpatient (including partial care) or an outpatient basis) and shall meet the following criteria:

1 The course of treatment shall be prescribed by and supervised by a qualified mental health provider (refer to Chapter 4, paragraph C.3.i.) practicing within the scope of his or her license. When indicated by the patient's physical status, the patient shall be under the general supervision of a physician.

2 The type and level of care provided by the facility are otherwise authorized by this Regulation.

3 The facility shall meet all licensing and other certification requirements of the jurisdiction in which the facility is located.

4 The facility shall be accredited by and shall remain in substantial compliance with standards issued by either the Joint Commission on Accreditation of Healthcare Organizations under the Consolidated Standards Manual, or the Commission Accreditation of Rehabilitation Facilities (CARF) or shall meet such other requirements as the Director, OCHAMPUS, finds necessary in the interest of the health and safety of the individuals who are furnished services in the facility.

5 The facility shall have entered into a participation agreement with OCHAMPUS within which the facility agrees, in part, to:

a Accept payment for its services based on an allowable-cost rate acceptable to the Director, OCHAMPUS, or such other method as determined by the Director, OCHAMPUS;

b Furnish OCHAMPUS with cost data certified to by an independent accounting firm or other agency as authorized by the Director, OCHAMPUS;

c Accept the CHAMPUS-determined rate as payment in full and to collect from the CHAMPUS beneficiary those amounts that represent the beneficiary's liability, as defined in Chapter 4, and charges for services and supplies that are not a benefit of CHAMPUS;

d Make all reasonable efforts acceptable to the Director, OCHAMPUS, to collect those amounts which represent the beneficiary's liability, as defined in Chapter 4;

e Permit access by the Director, OCHAMPUS, to clinical records of CHAMPUS beneficiaries and to the financial and organizational records of the facility;

f Comply with the provisions of Chapter 8, and to submit claims first to all health insurance coverage to which the beneficiary is entitled that is primary to CHAMPUS.

6 The substance use rehabilitation facility shall not be considered to be a CHAMPUS-authorized provider and CHAMPUS benefits shall not be paid for services provided by the substance use rehabilitation facility until the date the participation agreement is signed by the Director, OCHAMPUS, or a designee.

7 The substance use rehabilitation facility is not designated by the Health Care Financing Administration as an alcohol and drug abuse hospital for purposes of applicability of the Medicare prospective payment system.

8 At a minimum, medical records will be maintained in accordance with the JCAHO Consolidated Standard Manual for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities and Facilities Serving the Mentally Retarded, along with the requirements set forth in Section 199.7(b)(3). The alcohol rehabilitation facility is responsible for assuring that patient services and all treatment are accurately documented and completed in a timely manner.

k. Birthing centers. A birthing center is a freestanding or institution-affiliated outpatient maternity care program which principally provides a planned course of outpatient prenatal care and outpatient childbirth service limited to low-risk pregnancies; excludes care for high-risk pregnancies; limits childbirth to the use of natural childbirth procedures; and provides immediate newborn care.

(1) Certification requirements. A birthing center which meets the following criteria may be designated as an authorized CHAMPUS institutional provider:

(a) The predominant type of service and level of care rendered by the center is otherwise authorized by this Regulation.

(b) The center is licensed to operate as a birthing center where such license is available, or is specifically licensed as a type of ambulatory health care facility where birthing center specific license is not available, and meets all applicable licensing or certification requirements that are extant in the state, county, municipality, or other political jurisdiction in which the center is located.

(c) The center is accredited by a nationally recognized accreditation organization whose standards and procedures have been determined to be acceptable by the Director, OCHAMPUS, or a designee.

(d) The center complies with the CHAMPUS birthing center standards set forth in this Chapter.

(e) The center has entered into a participation agreement with OCHAMPUS in which the center agrees, in part, to:

1 Participate in CHAMPUS and accept payment for maternity services based upon the reimbursement methodology for birthing centers;

2 Collect from the CHAMPUS beneficiary only those amounts that represent the beneficiary's liability under the participation agreement and the reimbursement methodology for birthing centers, and the amounts for services and supplies that are not a benefit of the CHAMPUS;

3 Permit access by the Director, OCHAMPUS, or a designee, to the clinical record of any CHAMPUS beneficiary, to the financial and organizational records of the center, and to reports of evaluations and inspections conducted by state or private agencies or organizations;

4 Submit claims first to all health benefit and insurance plans primary the CHAMPUS to which the beneficiary is entitled and to comply with the double coverage provisions of this Regulation.

5 Notify OCHAMPUS in writing within 7 days of the emergency transport of any CHAMPUS beneficiary from the center to an acute care hospital or of the death of any CHAMPUS beneficiary in the center.

(f) A birthing center shall not be a CHAMPUS-authorized institutional provider and CHAMPUS benefits shall not be paid for any service provided by a birthing center before the date the participation agreement is signed by the Director, OCHAMPUS, or a designee.

(2) CHAMPUS birthing center standards.

(a) Environment. The center has a safe and sanitary environment, properly constructed, equipped, and maintained to protect health and safety and meets the applicable provisions of the "Life Safety Code" of the National Fire Protection Association.

(b) Policies and procedures. The center has written administrative, fiscal, personnel and clinical policies and procedures which collectively promote the provision of high-quality maternity care and childbirth services in an orderly, effective, and safe physical and organizational environment.

(c) Informed consent. Each CHAMPUS beneficiary admitted to the center will be informed in writing at the time of admission of the nature and scope of the center's program and of the possible risks associated with maternity care and childbirth in the center.

(d) Beneficiary care. Each woman admitted will be cared for by or under the direct supervision of a specific physician or a specific certified nurse-midwife who is otherwise eligible as a CHAMPUS individual professional provider.

(e) Medical direction. The center has written memoranda of understanding (MOU) for routine consultation and emergency care with an obstetrician-gynecologist who is certified or is eligible for certification by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology and with a pediatrician who is certified or eligible for certification by the American Board of Pediatrics or by the American Osteopathic Board of Pediatrics, each of whom have admitting privileges to at least one back-up hospital. In lieu of a required MOU, the center may employ a physician with the required qualifications. Each MOU must be renewed annually.

(f) Admission and emergency care criteria and procedures. The center has written clinical criteria and administrative procedures, which are reviewed and approved annually by a physician related to the center as required by subparagraph (e) above, for the exclusion of a woman with a high-risk pregnancy from center care and for management of maternal and neonatal emergencies.

(g) Emergency treatment. The center has a written memorandum of understanding (MOU) with at least one backup hospital which documents that the hospital will accept and treat any woman or newborn transferred from the center who is in need of emergency obstetrical or neonatal medical care. In lieu of this MOU with a hospital, a birthing center may have an MOU with a physician, who otherwise meets the requirements as a CHAMPUS individual professional provider, and who has admitting privileges to a back-up hospital capable of providing care for critical maternal and neonatal patients as demonstrated by a letter from that hospital certifying the scope and expected duration of the admitting privileges granted by the hospital to the physician. The MOU must be renewed annually.

(h) Emergency medical transportation. The center has a written memorandum of understanding (MOU) with at least one ambulance service which documents that the ambulance service is routinely staffed by qualified personnel who are capable of the management of critical maternal and neonatal patients during transport and which specifies the estimated transport time to each backup hospital with which the center has arranged for emergency treatment as required in subparagraph (g) above. Each MOU must be renewed annually.

(i) Professional staff. The center's professional staff is legally and professionally qualified for the performance of their professional responsibilities.

(j) Medical records. The center maintains full and complete written documentation of the services rendered to each woman admitted and each newborn delivered. A copy of the informed consent document required by subparagraph (c), above, which contains the original signature of the CHAMPUS beneficiary, signed and dated at the time of admission, must be maintained in the medical record of each CHAMPUS beneficiary admitted.

(k) Quality assurance. The center has an organized program for quality assurance which includes, but is not limited to, written procedures for regularly scheduled evaluation of each type of service provided, of each mother or newborn transferred to a hospital, and of each death within the facility.

(l) Governance and administration. The center has a governing body legally responsible for overall operation and maintenance of the center and a full-time employee who has authority and responsibility for the day-to-day operation of the center.

C. INDIVIDUAL PROFESSIONAL PROVIDERS OF CARE

1. General. Individual professional providers of care are those providers who bill for their services on a fee-for-service basis and are not employed or contracted with by an institutional provider. This category also includes those individuals who have formed professional corporations or associations qualifying as a domestic corporation under section 301.7701-5 of the Internal Revenue Service Regulations (reference (cc)). Such individual professional providers must be licensed or certified by the local licensing or certifying agency for the jurisdiction in which the care is provided; or in the absence of state licensure/certification, be a member of or demonstrate eligibility for full clinical membership in, the appropriate national or professional certifying association that sets standards for the profession of which the provider is a member. Services provided must be in accordance with good medical practice and prevailing standards of quality of care and within recognized utilization norms.

a. Licensing/Certification required, scope of license. Otherwise covered services shall be cost-shared only if the individual professional provider holds a current, valid license or certification to practice his or her profession in the jurisdiction where the service is rendered. Licensure/certification must be at the full clinical practice level. The services provided must be within the scope of the license, certification or other legal authorization. Licensure or certification is required to be a CHAMPUS authorized provider if offered in the jurisdiction where the service is rendered, whether such licensure or certification is required by law or provided on a voluntary basis. The requirement also applies for those categories of providers that would otherwise be exempt by the state because the provider is working in a non-profit, state-owned or church setting. Licensure/certification is mandatory for a provider to become a CHAMPUS-authorized provider.

b. Monitoring required. The Director, OCHAMPUS, or a designee, shall develop appropriate monitoring programs and issue guidelines, criteria, or norms necessary to ensure that CHAMPUS expenditures are limited to necessary medical supplies and services at the most reasonable cost to the government and beneficiary. The Director, OCHAMPUS, or a designee, also will take such steps as necessary to deter overutilization of services.

c. Christian Science. Christian Science practitioners and Christian Science nurses are authorized to provide services under CHAMPUS. Inasmuch as they provide services of an extramedical nature, the general criteria outlined above do not apply to Christian Science services (refer to subparagraph C.3.d.(2), below, regarding services of Christian Science practitioners and nurses).

d. Physician referral and supervision. Physician referral and supervision is required for the services of paramedical providers as listed in subparagraph C.3.c.8. and for marriage and family counselors, pastoral counselors, and mental health counselors. Physician referral means that the physician must actually see the patient, perform an evaluation, and arrive at an initial diagnostic impression prior to referring the patient. Documentation is required of the physician's examination, diagnostic impression, and referral. Physician supervision means that the physician provides overall medical management of the case. The physician does not have to be physically located on the premises of the provider to whom the referral is made. Communication back to the referring physician is an indication of medical management.

e. Medical records: Individual professional providers must maintain adequate clinical records to substantiate that specific care was actually furnished, was medically necessary, and appropriate, and identify(ies) the individual(s) who provided the care. This applies whether the care is inpatient or outpatient. The minimum requirements for medical record documentation are set forth by the following:

- (1) The cognizant state licensing authority;
- (2) The Joint Commission on Accreditation of Healthcare Organizations, or other health care accreditation organizations as may be appropriate;
- (3) Standards of practice established by national medical organizations; and
- (4) This Regulation.

2. Interns and residents. Interns and residents may not be paid directly by CHAMPUS for services rendered to a beneficiary when their services are provided as part of their employment (either salaried or contractual) by a hospital or other institutional provider.

3. Types of providers. Subject to the standards of participation provisions of this Regulation, the following individual professional providers of medical care are authorized to provide services to CHAMPUS beneficiaries:

a. Physicians

- (1) Doctors of Medicine (M.D.).
- (2) Doctors of Osteopathy (D.O.).

b. Dentists. Except for covered oral surgery as specified in section E. of Chapter 4 of this Regulation, all otherwise covered services rendered by dentists require preauthorization.

- (1) Doctors of Dental Medicine (D.M.D.).
- (2) Doctors of Dental Surgery (D.D.S.).

c. Other allied health professionals. The services of the following individual professional providers of care are coverable on a fee-for-service basis provided such services are otherwise authorized in this or other chapters of this Regulation.

(1) Clinical psychologist. For purposes of CHAMPUS, a clinical psychologist is an individual who is licensed or certified by the state for the independent practice of psychology and:

(a) Possesses a doctoral degree in psychology from a regionally accredited university; and

(b) Has had 2 years of supervised clinical experience in psychological health services of which at least 1 year is post-doctoral and 1 year (may be the post-doctoral year) is in an organized psychological health service training program; or

(c) As an alternative to (a) and (b) above, is listed in the National Register of Health Service Providers in Psychology (reference (ee)).

- (2) Doctors of Optometry.
- (3) Doctors of Podiatry or Surgical Chiropody.
- (4) Certified nurse midwives.

(a) A certified nurse midwife may provide covered care independent of physician referral and supervision, provided the nurse midwife is:

1 Licensed, when required, by the local licensing agency for the jurisdiction in which the care is provided; and

2 Certified by the American College of Nurse Midwives. To receive certification, a candidate must be a registered nurse who has completed successfully an educational program approved by the American College of Nurse Midwives, and passed the American College of Nurse Midwives National Certification Examination.

(b) The services of a registered nurse who is not a certified nurse midwife may be authorized only when the patient has been referred for care by a licensed physician and a licensed physician provides continuing supervision of the course of care. A lay midwife who is neither a certified nurse midwife nor a registered nurse is not a CHAMPUS-authorized provider, regardless of whether the services rendered may otherwise be covered.

(5) Certified nurse practitioner. Within the scope of applicable licensure or certification requirements, a certified nurse practitioner may provide covered care independent of physician referral and supervision, provided the nurse practitioner is:

(a) A licensed, registered nurse; and

(b) Specifically licensed or certified as a nurse practitioner by the state in which the care was provided, if the state offers such specific licensure or certification; or

(c) Certified as a nurse practitioner (certified nurse) by a professional organization offering certification in the speciality of practice, if the state does not offer specific licensure or certification for nurse practitioners.

(6) Certified Clinical Social Worker. A clinical social worker may provide covered services independent of physician referral and supervision, provided the clinical social worker:

(a) Is licensed or certified as a clinical social worker by the jurisdiction where practicing; or, if the jurisdiction does not provide for licensure or certification of clinical social workers, is certified by a national professional organization offering certification of clinical social workers; and

(b) Has at least a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education; and

b. Successive inpatient admissions. Successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the active duty dependent's share of the inpatient institutional charges, provided not more than 60 days have elapsed between the successive admissions, except that successive inpatient admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions. For the purpose of applying benefits, successive admissions will be determined separately for maternity admissions and admissions related to an accidental injury (refer to section F. of this chapter).

c. Related services and supplies. Covered services and supplies must be rendered in connection with and related directly to a covered diagnosis or definitive set of symptoms requiring otherwise authorized medically necessary treatment.

d. Inpatient, appropriate level required. For purposes of inpatient care, the level of institutional care for which Basic Program benefits may be extended must be at the appropriate level required to provide the medically necessary treatment except for patients requiring skilled nursing facility care. For patients for whom skilled nursing facility care is adequate, but is not available in the general locality, benefits may be continued in the higher level care facility. General locality means an area that includes all the skilled nursing facilities within 50 miles of the higher level facility, unless the higher level facility can demonstrate that the skilled nursing facilities are inaccessible to its patients. The decision as to whether a skilled nursing facility is within the higher level facility's general locality, or the skilled nursing facility is inaccessible to the higher level facility's patients shall be a CHAMPUS contractor initial determination for the purposes of appeal under chapter 10 of this regulation. CHAMPUS institutional benefit payments shall be limited to the allowable cost that would have been incurred in the skilled nursing facility, as determined by the Director, OCHAMPUS, or a designee. If it is determined that the institutional care can be provided reasonably in the home setting, no CHAMPUS institutional benefits are payable.

e. General or special education not covered. Services and supplies related to the provision of either regular or special education generally are not covered. Such exclusion applies whether a separate charge is made for education or whether it is included as a part of an overall combined daily charge of an institution. In the latter instance, that portion of the overall combined daily charge related to education must be determined, based on the allowable costs of the educational component, and deleted from the institution's charges before CHAMPUS benefits can be extended. The only exception is when appropriate education is not available from or not payable by the cognizant public entity. Each case must be referred to the Director, OCHAMPUS, or a designee, for review and a determination of the applicability of CHAMPUS benefits.

2. Covered hospital services and supplies

a. Room and board. Includes special diets, laundry services, and other general housekeeping support services (inpatient only).

b. General staff nursing services.

RESERVED

(1) Ambulance service is covered for emergency transfers from a beneficiary's place of residence, accident scene, or other location to a USMTF, and for transfer to a USMTF after treatment at, or admission to, a civilian hospital, if ordered by other than a representative of the USMTF.

(2) Ambulance service cannot be used instead of taxi service and is not payable when the patient's condition would have permitted use of regular private transportation; nor is it payable when transport or transfer of a patient is primarily for the purpose of having the patient nearer to home, family, friends, or personal physician. Except as described in subparagraph D.3.e.(1), above, transport must be to closest appropriate facility by the least costly means.

(3) Vehicles such as medicabs or ambicabs function primarily as public passenger conveyances transporting patients to and from their medical appointments. No actual medical care is provided to the patients in transit. These types of vehicles do not qualify for benefits for the purpose of CHAMPUS payment.

(4) Ambulance services by other than land vehicles (such as a boat or airplane) may be considered only when the pickup point is inaccessible by a land vehicle, or when great distance or other obstacles are involved in transporting the patient to the nearest hospital with appropriate facilities and the patient's medical condition warrants speedy admission or is such that transfer by other means is contraindicated.

f. Prescription drugs and medicines. Prescription drugs and medicines that by United States law require a physician's or other authorized individual professional provider's prescription (acting within the scope of their license) and that are ordered or prescribed by a physician or other authorized individual professional provider (except that insulin is covered for a known diabetic, even though a prescription may not be required for its purchase) in connection with an otherwise covered condition or treatment, including Rh immune globulin.

(1) Drugs administered by a physician or other authorized individual professional provider as an integral part of a procedure covered under sections B. or C. of this chapter (such as chemotherapy) are not covered under this subparagraph inasmuch as the benefit for the institutional services or the professional services in connection with the procedure itself also includes the drug used.

(2) CHAMPUS benefits may not be extended for drugs not approved by the U.S. Food and Drug Administration for commercial marketing. Drugs grandfathered by the Federal Food, Drug and Cosmetic Act of 1938 may be covered under CHAMPUS as if FDA approved.

g. Prosthetic devices. The purchase of prosthetic devices is limited to artificial limbs and eyes, except those items that are inserted surgically into the body as an essential and integral part of an otherwise covered surgical procedure are not excluded.

NOTE: In order for CHAMPUS benefits to be extended, any surgical implant must be approved for use in humans by the U.S. Food and Drug Administration. Devices that are approved only for investigational use in humans are not payable.

h. Orthopedic braces and appliances. The purchase of leg braces (including attached shoes), arm braces, back braces, and neck braces is covered. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes or regular shoes subsequently built up, are not covered.

E. SPECIAL BENEFIT INFORMATION

1. General. There are certain circumstances, conditions, or limitations that impact the extension of benefits and that require special emphasis and explanation. This section E. sets forth those benefits and limitations recognized to be in this category. The benefits and limitations herein described also are subject to all applicable definitions, conditions, limitations, exceptions, and exclusions as set forth in this or other chapters of this Regulation, except as otherwise may be provided specifically in this section E.

2. Abortion. The statute under which CHAMPUS operates prohibits payment for abortions with one single exception--where the life of the woman would be endangered if the fetus were carried to term. Covered abortion services are limited to medical services and supplies only. Physician certification is required attesting that the abortion was performed because the mother's life would have been endangered if the fetus were carried to term. Abortions performed for suspected or confirmed fetal abnormality (e.g., anencephalic) or for mental health reasons (e.g., threatened suicide) do not fall within the exceptions permitted within the language of the statute and are not authorized for payment under CHAMPUS.

NOTE: Covered abortion services are limited to medical services or supplies only for the single circumstance outlined above and do not include abortion counseling or referral fees. Payment is not allowed for any services involving preparation for, or normal followup to, a noncovered abortion. The Director, OCHAMPUS, or a designee, shall issue guidelines describing the policy on abortion.

3. Family planning. The scope of the CHAMPUS family planning benefit is as follows:

a. Birth control (such as contraception)

(1) Benefits provided. Benefits are available for services and supplies related to preventing conception, including the following:

(a) Surgical insertion, removal, or replacement of intrauterine devices.

(b) Measurement for, and purchase of, contraceptive diaphragms (and later remeasurement and replacement).

CHAPTER 6
AUTHORIZED PROVIDERS
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CHAPTER 6
AUTHORIZED PROVIDERS

A. GENERAL

This chapter sets forth general policies and procedures that are the basis for the CHAMPUS cost-sharing of medical services and supplies provided by institutions, individuals, or other types of providers. Providers seeking payment from the Federal Government through programs such as CHAMPUS have a duty to familiarize themselves with, and comply with, the program requirements.

1. Listing of provider does not guarantee payment of benefits. The fact that a type of provider is listed in this chapter is not to be construed to mean that CHAMPUS will automatically pay a claim for services or supplies provided by such a provider. The provider who actually furnishes the service(s) must, in fact, meet all licensing and other requirements established by this Regulation to be an authorized provider; the provider must not be the subject of sanction under Chapter 9; and, cost-sharing of the services must not otherwise be prohibited by this Regulation. In addition, the patient must in fact be an eligible beneficiary and the services or supplies billed must be authorized and medically necessary, regardless of the standing of the provider.

2. Outside the United States or emergency situations within the United States. Outside the United States or within the United States and Puerto Rico in emergency situations, the Director, OCHAMPUS, or a designee, after review of the facts, may provide payment to or on behalf of a beneficiary who receives otherwise covered services or supplies from a provider of service that does not meet the standards described in this Regulation.

NOTE: Only the Secretary of Defense, the Secretary of Health and Human Services, or the Secretary of Transportation, or their designees, may authorize (in emergency situations) payment to civilian facilities in the United States that are not in compliance with title VI of the Civil Rights Act of 1964 (reference (z)). For the purpose of the Civil Rights Act only, the United States includes the 50 states, the District of Columbia, Puerto Rico, Virgin Islands, American Samoa, Guam, Wake Island, Canal Zone, and the territories and possessions of the United States.

3. Dual compensation/conflict of interest. Title 5, United States Code, section 5536 (reference (bb)) prohibits medical personnel who are active duty Uniformed Service members or civilian employees of the Government from receiving additional Government compensation above their normal pay and allowances for medical care furnished. In addition, Uniformed Service members and civilian employees of the Government are generally prohibited by law and agency regulations and policies from participating in apparent or actual conflict of interest situations in which a potential for personal gain

exists or in which there is an appearance of impropriety or incompatibility with the performance of their official duties or responsibilities. The Departments of Defense, Health and Human Services, and Transportation have a responsibility, when disbursing appropriated funds in the payment of CHAMPUS benefits, to ensure that the laws and regulations are not violated. Therefore, active duty Uniformed Service members (including a reserve member while on active duty) and civilian employees of the United States Government shall not be authorized to be CHAMPUS providers. While individual employees of the Government may be able to demonstrate that the furnishing of care to CHAMPUS beneficiaries may not be incompatible with their official duties and responsibilities, the processing of millions of CHAMPUS claims each year does not enable Program administrators to efficiently review the status of the provider on each claim to ensure that no conflict of interest or dual compensation situation exists. The problem is further complicated given the numerous interagency agreements (for example, resource sharing arrangements between the Department of Defense and the Veterans Administration in the provision of health care) and other unique arrangements which exist at individual treatment facilities around the country. While an individual provider may be prevented from being an authorized CHAMPUS provider even though no conflict of interest or dual compensation situation exists, it is essential for CHAMPUS to have an easily administered, uniform rule which will ensure compliance with the existing laws and regulations. Therefore, a provider who is an active duty Uniformed Service member or civilian employee of the Government shall not be an authorized CHAMPUS provider. In addition, a provider shall certify on each CHAMPUS claim that he/she is not an active duty Uniformed Service member or civilian employee of the Government.

4. For-profit institutions excluded under the Program for the Handicapped (PFTH). 10 U.S.C. 1079(d)(4) (reference (a)) precludes payment of benefits under the PFTH for otherwise covered services and supplies provided by a for-profit institution (refer to Chapter 5 of this Regulation).

5. Utilization review and quality assurance. Providers approved as authorized CHAMPUS providers have certain obligations to provide services and supplies under CHAMPUS which are (i) furnished at the appropriate level and only when and to the extent medically necessary under the criteria of this Regulation; (ii) of a quality that meets professionally recognized standards of health care; and, (iii) supported by adequate medical documentation as may be reasonably required under this Regulation by the Director, OCHAMPUS, or a designee, to evidence the medical necessity and quality of services furnished, as well as the appropriateness of the level of care. Therefore, the authorization of CHAMPUS benefits is contingent upon the services and supplies furnished by any provider being subject to pre-payment or post-payment utilization and quality assurance review under professionally recognized standards, norms, and criteria, as well as any standards or criteria issued by the Director, OCHAMPUS, or a designee, pursuant to this Regulation. (Refer to Chapters 4, 5, and 7 of this Regulation.)

6. Exclusion of beneficiary liability. In connection with certain utilization review, quality assurance and preauthorization requirements of Chapter 4, providers may not hold patients liable for payment for certain services for which CHAMPUS payment is disallowed. With respect to such services, providers may not seek payment from the patient or the patient's family. Any such effort to seek payment is a basis for termination of the provider's authorized status.

7. Provider required. In order to be considered for benefits, all services and supplies shall be rendered by, prescribed by, or furnished at the direction of, or on the order of a CHAMPUS-authorized provider practicing within the scope of his or her license.

8. Participating provider. Under CHAMPUS, authorized professional providers and institutional providers other than hospitals have the option of participating on a claim-by-claim basis. Participation is required for inpatient claims only for hospitals which are Medicare-participating providers. Hospitals which are not Medicare-participating providers but which are subject to the CHAMPUS DRG-based payment system in subsection A.1. of Chapter 14 or the CHAMPUS mental health per diem payment system in subsection A.2. of Chapter 14 must sign agreements to participate on all CHAMPUS inpatient claims in order to be authorized providers under CHAMPUS. All other hospitals may elect to participate on a claim-by-claim basis. Participating providers must indicate participation by signing the appropriate space on the applicable CHAMPUS claim form and submitting it to the appropriate CHAMPUS fiscal intermediary on behalf of the beneficiary. In the case of an institution or medical supplier, the claim must be signed by an official having such authority. This certifies that the provider has agreed to accept the CHAMPUS-determined allowable charge or cost as payment in full for the medical services and supplies listed on the specific claim form; and has agreed to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing and deductible amounts paid by, or on behalf of, the beneficiary as full payment for the covered medical services and supplies.

9. Limitation to authorized institutional provider designation. Authorized institutional provider status granted to a specific institutional provider applicant does not extend to any institution-affiliated provider, as defined in Chapter 2 of this Regulation, of that specific applicant.

10. Authorized provider. A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized in this chapter to provide benefits under CHAMPUS. In addition, to be an authorized CHAMPUS provider, any hospital which is a CHAMPUS participating provider under Section A.7. of this chapter, shall be a participating provider for all care, services, or supplies furnished to an active duty member of the uniformed services for which the active duty member is entitled under title 10, United States Code, section 1074(c). As a participating provider for active duty members, the CHAMPUS authorized hospital shall provide such care, services, and supplies in accordance with the payment

rules of Chapter 16. The failure of any CHAMPUS participating hospital to be a participating provider for any active duty member subjects the hospital to termination of the hospital's status as a CHAMPUS authorized provider for failure to meet the qualifications established by this chapter.

B. INSTITUTIONAL PROVIDERS

1. General. Institutional providers are those providers who bill for services in the name of an organizational entity (such as hospital and skilled nursing facility), rather than in the name of a person. The term "institutional provider" does not include professional corporations or associations qualifying as a domestic corporation under section 301.7701-5 of the Internal Revenue Service Regulations (reference (cc)), nor does it include other corporations that provide principally professional services. Institutional providers may provide medical services and supplies on either an inpatient or outpatient basis.

a. Preauthorization. The Director, OCHAMPUS, reserves the right to require preauthorization for admission to inpatient facilities. Refer to Chapter 4, subsection A.11., for information on preauthorization.

b. Billing practices.

(1) Each institutional billing, including those institutions subject to the CHAMPUS DRG-based reimbursement method or a CHAMPUS-determined all-inclusive rate reimbursement method, must be itemized fully and sufficiently descriptive for the CHAMPUS to make a determination of benefits.

(2) Institutional claims subject to the CHAMPUS DRG-based reimbursement method or a CHAMPUS-determined all-inclusive rate reimbursement method, may be submitted only after the beneficiary has been discharged or transferred from the institutional provider's facility or program.

(3) Institutional claims for Residential Treatment Centers and all other institutional providers, except those listed in subparagraph (2) above, should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days.

c. Medical records. Institutional providers must provide adequate contemporaneous clinical records to substantiate that specific care was actually furnished, was medically necessary, and appropriate, and to identify the individual(s) who provided the care. The minimum requirements for medical record documentation are set forth by the following:

(1) The cognizant state licensing authority;

(2) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or other health care accreditation organizations as may be appropriate;

(3) Standards of practice established by national medical organizations; and

(4) This Regulation.

2. Nondiscrimination policy. Except as provided below, payment may not be made for inpatient or outpatient care provided and billed by an institutional provider found by the Federal Government to practice discrimination in the admission of patients to its services on the basis of race, color, or national origin. Reimbursement may not be made to a beneficiary who pays for care provided by such a facility and submits a claim for reimbursement. In the following circumstances, the Secretary of Defense, or a designee, may authorize payment for care obtained in an ineligible facility:

a. Emergency care. Emergency inpatient or outpatient care.

b. Care rendered before finding of a violation. Care initiated before a finding of a violation and which continues after such violation when it is determined that a change in the treatment facility would be detrimental to the health of the patient, and the attending physician so certifies.

c. Other facility not available. Care provided in an ineligible facility because an eligible facility is not available within a reasonable distance.

3. Procedures for qualifying as a CHAMPUS-approved institutional provider. General and special hospitals otherwise meeting the qualifications outlined in paragraphs B.4.a., b., and c., of this chapter are not required to request CHAMPUS approval formally.

a. JCAHO accreditation status. Each CHAMPUS fiscal intermediary shall keep informed as to the current JCAHO accreditation status of all hospitals and skilled nursing facilities in its area; and the provider's status under Medicare, particularly with regard to compliance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d(1)). The Director, OCHAMPUS, or a designee, shall specifically approve all other authorized institutional providers providing services to CHAMPUS beneficiaries. At the discretion of the Director, OCHAMPUS, any facility that is certified and participating as a provider of services under title XVIII of the Social Security Act (Medicare), may be deemed to meet CHAMPUS requirements. The facility must be providing a type and level of service that is authorized by this Regulation.

b. Required to comply with criteria. Facilities seeking CHAMPUS approval will be expected to comply with appropriate criteria set forth in subsection B.4. of this chapter. An onsite evaluation, either scheduled or unscheduled, may be conducted at the discretion of the Director, OCHAMPUS, or a designee. The final determination regarding approval, reapproval, or disapproval of a facility will be provided in writing to the facility and the appropriate CHAMPUS fiscal intermediary.

c. Notice of peer review rights. All health care facilities subject to the DRG-based payment system shall provide CHAMPUS beneficiaries, upon admission, with information about peer review including their appeal rights. The notices shall be in a form specified by the Director, OCHAMPUS.

d. Surveying of facilities. The surveying of newly established institutional providers and the periodic resurveying of all authorized institutional providers is a continuing process conducted by OCHAMPUS.

e. Institutions not in compliance with CHAMPUS standards. If a determination is made that an institution is not in compliance with one or more of the standards applicable to its specific category of institution, OCHAMPUS shall take immediate steps to bring about compliance or terminate the approval as an authorized institution in accordance with Chapter 9.F.2.

f. Participation agreements required for some hospitals which are not Medicare-participating. Notwithstanding the provisions of this paragraph B.3., a hospital which is subject to the CHAMPUS DRG-based payment system but which is not a Medicare-participating hospital must request and sign an agreement with OCHAMPUS. By signing the agreement, the hospital agrees to participate on all CHAMPUS inpatient claims and accept the requirements for a participating provider as contained in subsection A.7. of this chapter. Failure to sign such an agreement shall disqualify such hospital as a CHAMPUS-approved institutional provider.

4. Categories of institutional providers. The following categories of institutional providers may be reimbursed by CHAMPUS for services provided CHAMPUS beneficiaries subject to any and all definitions, conditions, limitations, and exclusions specified or enumerated in this Regulation.

a. Hospitals, acute care, general and special. An institution that provides inpatient services, that also may provide outpatient services (including clinical and ambulatory surgical services), and that:

(1) Is engaged primarily in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the medical or surgical diagnosis and treatment of illness, injury, or bodily malfunction (including maternity).

(2) Maintains clinical records on all inpatients (and outpatients if the facility operates an outpatient department or emergency room).

(3) Has bylaws in effect with respect to its operations and medical staff.

(4) Has a requirement that every patient be under the care of a physician.

(5) Provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times.

(6) Has in effect a hospital utilization review plan that is operational and functioning.

(7) In the case of an institution in a state in which state or applicable local law provides for the licensing of hospitals, the hospital:

(a) Is licensed pursuant to such law, or

(b) Is approved by the agency of such state or locality responsible for licensing hospitals as meeting the standards established for such licensing.

(8) Has in effect an operating plan and budget.

(9) Is accredited by the JCAHO or meets such other requirements as the Secretary of Health and Human Services or the Secretary of Defense finds necessary in the interest of the health and safety of patients who are admitted to and furnished services in the institution.

b. Liver transplantation centers.

(1) CHAMPUS shall provide coverage for liver transplantation procedures performed only by experienced transplant surgeons at centers complying with the provisions outlined in paragraph B.4.a. of this section and meeting the following criteria:

(a) The center is a tertiary care facility affiliated with an academic health center. The center must have accredited programs in graduate medical education related to the function of liver transplantation such as internal medicine, pediatrics, surgery, and anesthesiology;

(b) The center has an active solid organ transplantation program (involving liver transplants as well as other organs);

(c) The transplantation center must have at least a 50 percent one-year survival rate for ten cases. At the time CHAMPUS approval is requested, the transplant center must provide evidence that at least ten liver transplants have been performed at the center and that at least 50 percent of those transplanted patients have survived one year following surgery. A 50 percent one-year survival rate for all subsequent liver transplantations must be maintained for continued CHAMPUS approval;

(d) The center has allocated sufficient operating room, recovery room, laboratory, and blood bank support and a sufficient number of intensive care and general surgical beds and specialized staff for these areas;

(e) The center participates in a donor procurement program and network;

(f) The center systematically collects and shares data on its transplant program;

(g) The center has an interdisciplinary body to determine the suitability of candidates for transplantation on an equitable basis;

(h) The transplantation surgeon is specifically trained for liver grafting and must assemble and train a team to function whenever a donor liver is available;

(i) The transplantation center must have on staff board eligible or board certified physicians and other experts in the field of hepatology, pediatrics, infectious disease, nephrology with dialysis capability, pulmonary medicine with respiratory therapy support, pathology, immunology, and anesthesiology to complement a qualified transplantation team;

(j) The transplantation center has the assistance of appropriate microbiology, clinical chemistry, and radiology support;

(k) The transplantation center has blood bank support to accommodate normal demands and the transplant procedure; and

(l) The transplantation center includes the availability of psychiatric and social services support for patients and family.

(2) In order to receive approval as a CHAMPUS authorized liver transplant center, a center must submit a request to the Director, OCHAMPUS, or a designee. The CHAMPUS authorized liver transplant center shall agree to the following:

(a) Bill for all services and supplies related to the liver transplantation performed by its staff and bill also for services rendered by the donor hospital following declaration of brain death and after all existing legal requirements for excision of the donor organ have been met; and

(b) The center shall agree to submit all charges on the basis of fully itemized bills. This means that each service and supply and the charge for each is individually identified.

c. Heart transplantation centers.

(1) CHAMPUS shall provide coverage for heart transplantation procedures performed only by experienced transplant surgeons at centers complying with provisions outlined in paragraph B.4.a. of this section and meeting the following criteria:

(a) The center has experts in the fields of cardiology, cardiovascular surgery, anesthesiology, immunology, infectious disease, nursing, social services and organ procurement to complement the transplant team;

(b) The center has an active cardiovascular medical and surgical program as evidenced by a minimum of 500 cardiac catheterizations and coronary arteriograms and 250 open heart procedures per year;

(c) The center has an anesthesia team that is available at all times;

(d) The center has infectious disease services with both the professional skills and the laboratory resources that are needed to discover, identify, and manage a whole range of organisms;

(e) The center has a nursing service team trained in the hemodynamic support of the patient and in managing immunosuppressed patients;

(f) The center has pathology resources that are available for studying and reporting the pathological responses of transplantation;

(g) The center has legal counsel familiar with transplantation laws and regulations;

(h) The commitment of the transplant center must be at all levels and broadly evident throughout the facility;

(i) Responsible team members must be board certified or board eligible in their respective disciplines;

(j) Component teams must be integrated into a comprehensive transplant team with clearly defined leadership and responsibility;

(k) The center has adequate social service resources;

(l) The transplant center must comply with applicable State transplant laws and regulations;

(m) The transplant center must safeguard the rights and privacy of patients;

- (n) The transplant center must have adequate patient management plans and protocols;
 - (o) The center participates in a donor procurement program and network;
 - (p) The center systematically collects and shares data on its transplant program;
 - (q) The center has an interdisciplinary body to determine the suitability of candidates for transplantation on an equitable basis;
 - (r) The center has extensive blood bank support;
 - (s) The center must have an established heart transplantation program with documented evidence of 12 or more heart transplants in each of the two consecutive preceding 12-month periods prior to application and 12 heart transplants prior to that; and
 - (t) The center must demonstrate actuarial survival rates of 73 percent for one year and 65 percent for two years for patients who have had heart transplants since January 1, 1982, at that facility.
- (2) CHAMPUS approval will lapse if either the number of heart transplants falls below 8 in 12 months or if the one-year survival rate falls below 60 percent for a consecutive 24-month period.
- (3) CHAMPUS-approval may also be extended for a heart transplant center that meets other certification or accreditation standards provided the standards are equivalent to or exceed the criteria listed above and have been approved by the Director, OCHAMPUS.
- (4) In order to receive approval as a CHAMPUS heart transplant center, a facility must submit a request to the Director, OCHAMPUS, or a designee. The CHAMPUS-authorized heart transplant center shall agree to the following:
- (a) Bill for all services and supplies related to the heart transplantation performed by its staff and bill also for services rendered by the donor hospital following declaration of brain death;
 - (b) Submit all charges on the basis of fully itemized bills. Each service and supply must be individually identified and the first claim submitted for the heart transplantation must include a copy of the admission history and physical examination; and
 - (c) Report any significant decrease in the experience level or survival rates and loss of key members of the transplant team to the Director, OCHAMPUS.

SUPPLEMENTARY

INFORMATION

DEPARTMENT OF DEFENSE
PUBLICATION SYSTEM

CHANGE TRANSMITTAL

OFFICE OF THE SECRETARY OF DEFENSE
Assistant Secretary of Defense (Health Affairs)

CHANGE NO. 5
to July 1991, Reprint
DoD 6010.8-R
September 17, 1993

CIVILIAN HEALTH AND MEDICAL PROGRAM
OF THE UNIFORMED SERVICES (CHAMPUS)

The Acting Assistant Secretary of Defense (Health Affairs) has authorized the withdrawal of Change No. 4 to DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," July 1991 (Reprint). The attached replacement pages will implement the Partial Hospitalization Benefit and restore the Regulation to its former text prior to Change No. 4.

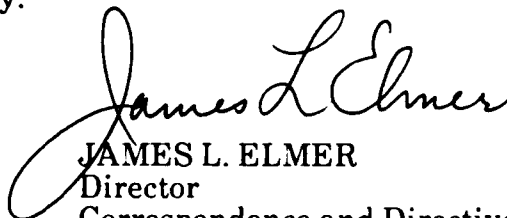
PAGE CHANGES

Remove: 2-i through 2-iv, 2-3&2-4, 2-9&2-10, 2-19 through 2-26, 4-i through 4-viii, 4-5&4-6, 4-11&4-12, 4-13b&4-14, 4-21 through 4-24, 4-44&4-45, 6-i&6-ii, 6-17 through 6-20, 6-23&6-24, 7-7&7-8, 14-i&14-ii, 14-17&14-18

Insert: Attached replacement pages

EFFECTIVE DATE

The above changes are effective immediately.


JAMES L. ELMER
Director
Correspondence and Directives

Attachments
57 pages

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, THIS TRANSMITTAL SHOULD BE FILED WITH THE BASIC DOCUMENT

AD-A268 034

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Admission. The formal acceptance by a CHAMPUS authorized institutional provider of a CHAMPUS beneficiary for the purpose of diagnosis and treatment of illness, injury, pregnancy, or mental disorder.

Adopted Child. A child taken into one's own family by legal process and treated as one's own child. In case of adoption, CHAMPUS eligibility begins as of 12:01 a.m. of the day of the final adoption decree. NOTE: There is no CHAMPUS benefit entitlement during any interim waiting period.

All-Inclusive Per Diem Rate. The OCHAMPUS determined rate that encompasses the daily charge for inpatient care and, unless specifically excepted, all other treatment determined necessary and rendered as part of the treatment plan established for a patient, and accepted by OCHAMPUS.

Allowable Charge. The CHAMPUS-determined level of payment to physicians, other individual professional providers and other providers, based on one of the approved reimbursement methods set forth in Chapter 14 of this Regulation. Allowable charge also may be referred to as the CHAMPUS-determined reasonable charge.

Allowable Cost. The CHAMPUS-determined level of payment to hospitals or other institutions, based on one of the approved reimbursement methods set forth in Chapter 14 of this Regulation. Allowable cost may also be referred to as the CHAMPUS-determined reasonable cost.

Ambulance. A specially designed vehicle for transporting the sick or injured that contains a stretcher, linens, first aid supplies, oxygen equipment, and such lifesaving equipment required by state and local law, and that is staffed by personnel trained to provide first aid treatment.

Amount in Dispute. The amount of money, determined under this Regulation, that CHAMPUS would pay for medical services and supplies involved in an adverse determination being appealed if the appeal were resolved in favor of the appealing party. See Chapter 10 for additional information concerning the determination of "amount in dispute" under this Regulation.

Anesthesia Services. The administration of an anesthetic agent by injection or inhalation, the purpose and effect of which is to produce surgical anesthesia characterized by muscular relaxation, loss of sensation, or loss of consciousness when administered by or under the direction of a physician or dentist in connection with otherwise covered surgery or obstetrical care, or shock therapy. Anesthesia services do not include hypnosis or acupuncture.

Appealable Issue. Disputed questions of fact which, if resolved in favor of the appealing party, would result in the authorization of CHAMPUS benefits, or approval as an authorized provider in accordance with this Regulation. An appealable issue does not exist if no facts are in dispute, if no CHAMPUS benefits would be payable, or if there is no authorized provider, regardless of the resolution of any disputed facts. See Chapter 10 for additional information concerning the determination of "appealable issue" under this Regulation.

Appealing Party. Any party to the initial determination who files an appeal of an adverse determination or requests a hearing under the provisions of this Regulation.

Appropriate Medical Care

1. Services performed in connection with the diagnosis or treatment of disease or injury, pregnancy, mental disorder, or well-baby care which are in keeping with the generally accepted norms for medical practice in the United States;

2. The authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training and education and is licensed or certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards; and

3. The services are furnished economically. For purposes of this Regulation, "economically" means that the services are furnished in the least expensive level of care or medical environment adequate to provide the required medical care regardless of whether or not that level of care is covered by CHAMPUS.

Attending Physician. The physician who has the primary responsibility for the medical diagnosis and treatment of the patient. A consultant, an assistant-at-surgery or an anesthesiologist is not an attending physician. Under very extraordinary circumstances, because of the presence of complex, serious, and multiple, but unrelated, medical conditions, a patient may have more than one attending physician concurrently rendering medical treatment during a single period of time.

Authorized Provider. A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized to provide benefits under CHAMPUS in Chapter 6 of this Regulation.

Backup Hospital. A hospital which is otherwise eligible as a CHAMPUS institutional provider and which is fully capable of providing emergency care to a patient who develops complications beyond the scope of services of a given category of CHAMPUS authorized freestanding institutional provider and which is accessible from the site of the CHAMPUS authorized freestanding institutional provider within an average transport time acceptable for the types of medical emergencies usually associated with the type of care provided by the freestanding facility.

Basic Program. The primary medical benefits authorized under Chapter 55 of title 10, United States Code, and set forth in Chapter 4 of this Regulation.

Beneficiary. An individual who has been determined to be eligible for CHAMPUS benefits, as set forth in Chapter 3 of this Regulation.

specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment. A custodial care determination is not precluded by the fact that a patient is under the care of a supervising or attending physician and that services are being ordered and prescribed to support and generally maintain the patient's condition, or provide for the patient's comfort, or ensure the manageability of the patient. Further, a custodial care determination is not precluded because the ordered and prescribed services and supplies are being provided by an R.N., L.P.N., or L.V.N.

NOTE: The determination of custodial care in no way implies that the care being rendered is not required by the patient; it only means that it is the kind of care that is not covered under CHAMPUS. A program of physical and mental rehabilitation which is designed to reduce a disability is not custodial care as long as the objective of the program is a reduced level of care.

Days. Calendar days.

Deceased Service Member. A person who, at the time of his or her death, was an active duty member of a Uniformed Service under a call or order that did not specify a period of 30 days or less; or a retiree of a Uniformed Service.

Deductible. Payment by a beneficiary of the first \$50 of the CHAMPUS-determined allowable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year; or for a family, the aggregate payment by two or more beneficiaries who submit claims of the first \$100.

Deductible Certificate. A statement issued to the beneficiary (or sponsor) by a CHAMPUS fiscal intermediary certifying to deductible amounts satisfied by a CHAMPUS beneficiary for any applicable fiscal year.

Defense Enrollment Eligibility Reporting System (DEERS). The automated system that is composed of two phases:

1. Enrolling all active duty and retired service members, their dependents, and the dependents of deceased service members, and
2. Verifying their eligibility for health care benefits in the direct care facilities and through CHAMPUS.

Dental Care. Services relating to the teeth and their supporting structures.

Dentist. Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery (D.D.S.) who is licensed to practice dentistry by an appropriate authority.

Dependent. A person who bears any of the following relationships to an active duty member (under a call or order that does not specify a period of 30 days or less), retiree, or deceased active duty member or retiree, of a Uniformed Service, that is, lawful spouse, former spouse (in certain circumstances), unremarried widow or widower, or child; or a spouse and child of an active duty member of the armed forces of foreign North Atlantic Treaty Organization (NATO) nations (refer to section B. in Chapter 3 of this Regulation).

Deserter or Desertion Status. A service member is a deserter, or in a desertion status, when the Uniformed Service concerned has made an administrative determination to that effect, or the member's period of unauthorized absence has resulted in a court-martial conviction of desertion. Administrative declarations of desertion normally are made when a member has been an unauthorized absentee for over 30 days, but particular circumstances may result in an earlier declaration. Entitlement to CHAMPUS benefits ceases as of 12:01 a.m. on the day following the day the desertion status is declared. Benefits are not to be authorized for treatment received during a period of unauthorized absence that results in a court-martial conviction for desertion. Dependent eligibility for benefits is reestablished when a deserter is returned to military control and continues, even though the member may be in confinement, until any discharge is executed. When a deserter status is later found to have been determined erroneously, the status of deserter is considered never to have existed, and the member's dependents will have been eligible continuously for benefits under CHAMPUS.

Diagnosis-Related Groups (DRGs). Diagnosis-related groups (DRGs) are a method of dividing hospital patients into clinically coherent groups based on the consumption of resources. Patients are assigned to the groups based on their principal diagnosis (the reason for admission, determined after study), secondary diagnoses, procedures performed, and the patient's age, sex, and discharge status.

Diagnostic Admission. An admission to a hospital or other authorized institutional provider, or an extension of a stay in such a facility, primarily for the purpose of performing diagnostic tests, examinations, and procedures.

Doctor of Dental Medicine (D.M.D.). A person who has received a degree in dentistry, that is, that department of the healing arts which is concerned with the teeth, oral cavity, and associated structures.

body weight is 200 percent or more of the ideal weight for height and bone structure according to the most current Metropolitan Life Table. The associated medical conditions are diabetes mellitus, hypertension, cholecystitis, narcolepsy, pickwickian syndrome (and other severe respiratory diseases), hypothalamic disorders, and severe arthritis of the weight-bearing joints.

Most-Favored Rate. The lowest usual charge to any individual or third-party payer in effect on the date of the admission of a CHAMPUS beneficiary.

Natural Childbirth. Childbirth without the use of chemical induction or augmentation of labor or surgical procedures other than episiotomy or perineal repair.

Naturopath. A person who practices naturopathy, that is, a drugless system of therapy making use of physical forces such as air, light, water, heat, and massage. NOTE: Services of a naturopath are not covered by CHAMPUS.

Nonavailability Statement. A certification by a commander (or a designee) of a Uniformed Services medical treatment facility recorded on DD Form 1251, generally for the reason that the needed medical care being requested by a CHAMPUS beneficiary cannot be provided at the facility concerned because the necessary resources are not available.

Nonparticipating Provider. A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished medical services or supplies to a CHAMPUS beneficiary, but who did not agree on the CHAMPUS claim form to participate or to accept the CHAMPUS-determined allowable cost or charge as the total charge for the services. A nonparticipating provider looks to the beneficiary or sponsor for payment of his or her charge, not CHAMPUS. In such cases, CHAMPUS pays the beneficiary or sponsor, not the provider.

North Atlantic Treaty Organization (NATO) Member. A military member of an armed force of a foreign NATO nation who is on active duty and who, in connection with official duties, is stationed in or passing through the United States. The foreign NATO nations are Belgium, Canada, Denmark, France, Federal Republic of Germany, Greece, Iceland, Italy, Luxemburg, the Netherlands, Norway, Portugal, Spain, Turkey, and the United Kingdom.

Official Formularies. A book of official standards for certain pharmaceuticals and preparations that are not included in the U.S. Pharmacopeia.

Optometrist (Doctor of Optometry). A person trained and licensed to examine and test the eyes and to treat visual defects by prescribing and adapting corrective lenses and other optical aids, and by establishing programs of exercises.

Oral Surgeon (D.D.S. or D.M.D.). A person who has received a degree in dentistry and who limits his or her practice to oral surgery, that is, that branch of the healing arts that deals with the diagnosis and the surgical correction and adjunctive treatment of diseases, injuries, and defects of the mouth, the jaws, and associated structures.

Orthopedic Shoes. Shoes prescribed by an orthopedic surgeon to effect changes in foot or feet position and alignment and which are not an integral part of a brace.

Other Allied Health Professionals. Individual professional providers other than physicians, dentists, or extramedical individual providers, as specified in Chapter 6 of this Regulation.

Other Special Institutional Providers. Certain special institutional providers, either inpatient or outpatient, other than those specifically defined, that provide courses of treatment prescribed by a doctor of medicine or osteopathy; when the patient is under the supervision of a doctor of medicine or osteopathy during the entire course of the inpatient admission or the outpatient treatment; when the type and level of care and services rendered by the institution are otherwise authorized in this Regulation; when the facility meets all licensing or other certification requirements that are extant in the jurisdiction in which the facility is located geographically; which is accredited by the Joint Commission on Accreditation if an appropriate accreditation program for the given type of facility is available; and which is not a nursing home, intermediate facility, halfway house, home for the aged, or other institution of similar purpose.

Outpatient. A patient who has not been admitted to a hospital or other authorized institution as an inpatient.

Ownership or Control Interest. For purposes of Chapter 9.F.1., a "person with an ownership or control interest" is anyone who

1. Has directly or indirectly a 5 percent or more ownership interest in the entity; or
2. Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 percent of the total property and assets of the entity; or
3. Is an officer or director of the entity if the entity is organized as a corporation; or
4. Is a partner in the entity if the entity is organized as a partnership.

Partial Hospitalization. A treatment setting capable of providing an interdisciplinary program of medical therapeutic services at least 3 hours

per day, 5 days per week, which may embrace day, evening, night and weekend treatment programs which employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. Partial hospitalization is a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic environment. Partial hospitalization is an appropriate setting for crisis stabilization, treatment of partially stabilized mental health disorders, and a transition from an inpatient program when medically necessary. Such programs must enter into a participation agreement with CHAMPUS, and be accredited and in substantial compliance with the standards of the Mental Health Manual of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (formerly known as the Consolidated Standards).

Participating Provider. A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished services or supplies to a CHAMPUS beneficiary and that has agreed, by act of signing and submitting a CHAMPUS claim form and indicating participation in the appropriate space on the claim form, to accept the CHAMPUS-determined allowable cost or charge as the total charge (even though less than the actual billed amount), whether paid for fully by the CHAMPUS allowance or requiring cost-sharing by the beneficiary (or sponsor).

Party to a Hearing. An appealing party or parties and CHAMPUS.

Party to the Initial Determination. Includes CHAMPUS and also refers to a CHAMPUS beneficiary and a participating provider of services whose interests have been adjudicated by the initial determination. In addition, a provider who has been denied approval as an authorized CHAMPUS provider is a party to that initial determination, as is a provider who is disqualified or excluded as an authorized provider under CHAMPUS, unless the provider is excluded based on a determination of abuse or fraudulent practices or procedures under another federal or federally funded program. See Chapter 10 for additional information concerning parties not entitled to administrative review under the CHAMPUS appeals and hearing procedures.

Pharmacist. A person who is trained specially in the scientific basis of pharmacology and who is licensed to prepare and sell or dispense drugs and compounds and to make up prescriptions ordered by a physician.

Physical Medicine Services or Physiatry Services. The treatment of disease or injury by physical means such as massage, hydrotherapy, or heat.

Physical Handicap. A physical condition of the body that meets the following criteria:

1. Duration. The condition is expected to result in death, or has lasted, or with reasonable certainty is expected to last, for a minimum period of 12 months; and

2. Extent. The condition is of such severity as to preclude the individual from engaging in substantially basic productive activities of daily living expected of unimpaired persons of the same age group.

Physical Therapist. A person who is trained specially in the skills and techniques of physical therapy (that is, the treatment of disease by physical agents and methods such as heat, massage, manipulation, therapeutic exercise, hydrotherapy, and various forms of energy such as electrotherapy and ultrasound), who has been authorized legally (that is, registered) to administer treatments prescribed by a physician and who is entitled legally to use the designation "Registered Physical Therapist." A physical therapist also may be called a physiotherapist.

Physician. A person with a degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is licensed to practice medicine by an appropriate authority.

Podiatrist (Doctor of Podiatry or Surgical Chiropody). A person who has received a degree in podiatry (formerly called chiropody), that is, that specialized field of the healing arts that deals with the study and care of the foot, including its anatomy, pathology, and medical and surgical treatment.

Preauthorization. A decision issued in writing by the Director, OCHAMPUS, or a designee, that CHAMPUS benefits are payable for certain services that a beneficiary has not yet received.

Prescription Drugs and Medicines. Drugs and medicines which at the time of use were approved for commercial marketing by the U.S. Food and Drug Administration, and which, by law of the United States, require a physician's or dentist's prescription, except that it includes insulin for known diabetics whether or not a prescription is required. Drugs grandfathered by the Federal Food, Drug and Cosmetic Act of 1938 may be covered under CHAMPUS as if FDA approved.

NOTE: The fact that the U.S. Food and Drug Administration has approved a drug for testing on humans would not qualify it within this definition.

Preventive Care. Diagnostic and other medical procedures not related directly to a specific illness, injury, or definitive set of symptoms, or obstetrical care, but rather performed as periodic health screening, health assessment, or health maintenance.

Primary Payer. The plan or program whose medical benefits are payable first in a double coverage situation.

Private Duty (Special) Nursing Services. Skilled nursing services rendered to an individual patient requiring intensive medical care. Such private duty (special) nursing must be by an actively practicing registered nurse (R.N.) or licensed practical or vocational nurse (L.P.N. or L.V.N.) only when the medical condition of the patient requires intensive skilled nursing services (rather than primarily providing the essentials of daily living) and when such skilled nursing care is ordered by the attending physician.

Private Room. A room with one bed that is designated as a private room by the hospital or other authorized institutional provider.

Program for the Handicapped (PFTH). The special program set forth in Chapter 5 of this Regulation, through which dependents of active duty members receive supplemental benefits for the moderately or severely mentally retarded and the seriously physically handicapped over and above those medical benefits available under the Basic Program.

Progress notes. Progress notes are an essential component of the medical record wherein health care personnel provide written evidence of ordered and supervised diagnostic tests, treatments, medical procedures, therapeutic behavior and outcomes. In the case of mental health care, progress notes must include: the date of the therapy session; length of the therapy session; a notation of the patient's signs and symptoms; the issues, pathology and specific behaviors addressed in the therapy session; a statement summarizing the therapeutic interventions attempted during the therapy session; descriptions of the response to treatment, the outcome of the treatment, and the response to significant others; and a statement summarizing the patient's degree of progress toward the treatment goals. Progress notes do not need to repeat all that was said during a therapy session but must document a patient contact and be sufficiently detailed to allow for both peer review and audits to substantiate the quality and quantity of care rendered.

Prosthetic Device (Prosthesis). An artificial substitute for a missing body part.

Provider. A hospital or other institutional provider, a physician, or other individual professional provider, or other provider of services or supplies as specified in Chapter 6 of this Regulation.

Provider Exclusion and Suspension. The terms "exclusion" and "suspension", when referring to a provider under CHAMPUS, both mean the denial of status as an authorized provider, resulting in items, services, or supplies furnished by the provider not being reimbursed, directly or indirectly, under CHAMPUS. The terms may be used interchangeably to refer to a provider who has been denied status as an authorized CHAMPUS provider based on 1) a criminal conviction or civil judgment involving fraud, 2) an administrative finding of fraud or abuse under CHAMPUS, 3) an administrative finding that the provider has been excluded or suspended by another agency of the Federal Government, a state, or a local licensing authority, 4) an administrative finding that the provider has knowingly participated in a conflict of interest situation, or 5) an administrative finding that it is in the best interests of the CHAMPUS or CHAMPUS beneficiaries to exclude or suspend the provider.

Provider Termination. When a provider's status as an authorized CHAMPUS provider is ended, other than through exclusion or suspension, based on a finding that the provider does not meet the qualifications, as set forth in Chapter 6 of this Regulation, to be an authorized CHAMPUS provider.

Psychiatric Emergency. A psychiatric inpatient admission is an emergency when, based on a psychiatric evaluation performed by a physician (or other qualified mental health care professional with hospital admission authority), the patient is at immediate risk of serious harm to self or others as a result of a mental disorder and requires immediate continuous skilled observation at the acute level of care.

Radiation Therapy Services. The treatment of diseases by x-ray, radium, or radioactive isotopes when ordered by the attending physician.

Referral. The act or an instance of referring a CHAMPUS beneficiary to another authorized provider to obtain necessary medical treatment. Under CHAMPUS, only a physician may make referrals.

Registered Nurse. A person who is prepared specially in the scientific basis of nursing, who is a graduate of a school of nursing, and who is registered for practice after examination by a state board of nurse examiners or similar regulatory authority, who holds a current, valid license, and who is entitled legally to use the designation R.N.

Representative. Any person who has been appointed by a party to the initial determination as counsel or advisor and who is otherwise eligible to serve as the counsel or advisor of the party to the initial determination, particularly in connection with a hearing.

Resident (Medical). A graduate physician or dentist who has an M.D. or D.O. degree, or D.D.S. or D.M.D. degree, respectively, is licensed to practice, and who chooses to remain on the house staff of a hospital to get further training that will qualify him or her for a medical or dental specialty.

Residential Treatment Center (RTC). A facility (or distinct part of a facility) which meets the criteria in Chapter 6.B.4.

Retiree. A member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay based on duty in a Uniformed Service.

Routine Eye Examinations. The services rendered in order to determine the refractive state of the eyes.

Sanction. For purpose of Chapter 9, "sanction" means a provider exclusion, suspension, or termination.

Secondary Payer. The plan or program whose medical benefits are payable in double coverage situations only after the primary payer has adjudicated the claim.

Semiprivate Room. A room containing at least two beds. If a room is designated publicly as a semiprivate accommodation by the hospital or other authorized institutional provider and contains multiple beds, it qualifies as a semiprivate room for the purposes of CHAMPUS.

Skilled Nursing Facility. An institution (or a distinct part of an institution) that meets the criteria as set forth in subsection B.4. of Chapter 6 of this Regulation.

Skilled Nursing Service. A service that can only be furnished by an R.N., or L.P.N. or L.V.N., and is required to be performed under the supervision of a physician to ensure the safety of the patient and achieve the medically desired result. Examples of skilled nursing services are intravenous or intramuscular injections, levin tube or gastrostomy feedings, or tracheotomy aspiration and insertion. Skilled nursing services are other than those services that provide primarily support for the essentials of daily living or that could be performed by an untrained adult with minimum instruction or supervision.

Special Tutoring. Teaching or instruction provided by a private teacher to an individual usually in a private or separate setting to enhance the educational development of an individual in one or more study areas.

Spectacles, Eyeglasses, and Lenses. Lenses, including contact lenses, that help to correct faulty vision.

Sponsor. An active duty member, retiree, or deceased active duty member or retiree, of a Uniformed Service upon whose status his or her dependents' eligibility for CHAMPUS is based.

Spouse. A lawful wife or husband regardless of whether or not dependent upon the active duty member or retiree.

Student Status. A dependent of a member or former member of a Uniformed Service who has not passed his or her 23rd birthday, and is enrolled in a full-time course of study in an institution of higher learning.

Suppliers of Portable X-Ray Services. A supplier that meets the conditions of coverage of the Medicare program, set forth in the Medicare regulations (reference (m)), or the Medicaid program in the state in which the covered service is provided.

Surgery. Medically appropriate operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and those certain procedures listed in paragraph C.2.a. of Chapter 4 of this Regulation.

Surgical Assistant. A physician (or dentist or podiatrist) who assists the operating surgeon in the performance of a covered surgical service when such assistance is certified as necessary by the attending surgeon, when the type of surgical procedure being performed is of such complexity and seriousness as to require a surgical assistant, and when interns, residents, or other house staff are not available to provide the surgical assistance services in the specialty area required.

Suspension of Claims Processing. The temporary suspension of processing (to protect the government's interests) of claims for care furnished by a specific provider (whether the claims are submitted by the provider or beneficiary) or claims submitted by or on behalf of a specific CHAMPUS beneficiary pending action by the Director, OCHAMPUS, or a designee, in a case of suspected fraud or abuse. The action may include the administrative remedies provided for in Chapter 9 or any other Department of Defense issuance (e.g. DoD issuances implementing the Program Fraud Civil Remedies Act), case development or investigation by OCHAMPUS, or referral to the Department of Defense-Inspector General or the Department of Justice for action within their cognizant jurisdictions.

Timely Filing. The filing of CHAMPUS claims within the prescribed time limits as set forth in Chapter 7 of this Regulation.

Treatment Plan. A detailed description of the medical care being rendered or expected to be rendered a CHAMPUS beneficiary seeking approval for inpatient benefits for which preauthorization is required as set forth in section B. of Chapter 4 of this Regulation. A treatment plan must include, at a minimum, a diagnosis (either ICD-9-CM or DSM-III); detailed reports of prior treatment, medical history, family history, social history, and physical examination; diagnostic test results; consultant's reports (if any); proposed treatment by type (such as surgical, medical, and psychiatric); a description of who is or will be providing treatment (by discipline or specialty); anticipated frequency, medications, and specific goals of treatment; type of inpatient facility required and why (including length of time the related inpatient stay will be required); and prognosis. If the treatment plan involves the transfer of a CHAMPUS patient from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the treatment plan documentation.

Uniformed Services. The Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA.

Veteran. A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

NOTE: Unless the veteran is eligible for "retired pay," "retirement pay," or "retainer pay," which refers to payments of a continuing nature and are payable at fixed intervals from the government for military service neither the veteran nor his or her dependents are eligible for benefits under CHAMPUS.

Well-Baby Care. A specific program of periodic health screening, developmental assessment, and routine immunization for children from birth up to 2 years.

Widow or Widower. A person who was a spouse at the time of death of the active duty member or retiree and who has not remarried.

Worker's Compensation Benefits. Medical benefits available under any worker's compensation law (including the Federal Employees Compensation Act), occupational disease law, employers liability law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure.

X-Ray Services. An x-ray examination from which an x-ray film or other image is produced, ordered by the attending physician when necessary and rendered in connection with a medical or surgical diagnosis or treatment of an illness or injury, or in connection with maternity or well-baby care.

CHAPTER 4
BASIC PROGRAM BENEFITS
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d. Other preauthorization requirements

(1) The Director, OCHAMPUS, or a designee, shall respond to all requests for preauthorization in writing and shall send notification of approval or denial to the beneficiary.

(2) The Director, OCHAMPUS, or a designee, shall specify, in the approved preauthorization, the services and supplies the approval covers.

(3) An approved preauthorization is valid only for 90 days from the date of issuance. If the preauthorized services and supplies are not obtained or commenced within the 90-day period, a new preauthorization request is required.

(4) A preauthorization may set forth other special limits or requirements as indicated by the particular case or situation for which preauthorization is being issued.

12. Utilization review, quality assurance and preauthorization for inpatient mental health services and partial hospitalization.

a. In general. The Director, OCHAMPUS shall provide, either directly or through contract, a program of utilization and quality review for all mental health care services. Among other things, this program shall include mandatory preadmission authorization before nonemergency inpatient mental health services may be provided and mandatory approval of continuation of inpatient services within 72 hours of emergency admissions. This program shall also include requirements for other pretreatment authorization procedures, concurrent review of continuing inpatient and partial hospitalization care, retrospective review, and other such procedures as determined appropriate by the Director, OCHAMPUS. The provisions of paragraph H of this chapter and paragraph F, Chapter 15, shall apply to this program. The Director, OCHAMPUS, shall establish, pursuant to paragraph F., Chapter 15, procedures substantially comparable to requirements of paragraph H of this chapter and Chapter 15. If the utilization and quality review program for mental health care services is provided by contract, the contractor(s) need not be the same contractor(s) as are engaged under Chapter 15 in connection with the review of other services.

b. Preadmission authorization.

(1) This section generally requires preadmission authorization for all nonemergency inpatient mental health services and prompt continued stay authorization after emergency admissions. It also requires preadmission authorization for all admissions to a partial hospitalization program, without exception, as the concept of an emergency admission does not pertain to a partial hospitalization level of care. Institutional services for which payment would otherwise be authorized, but which were provided without compliance with preadmission authorization requirements, do not qualify for the same payment that would be provided if the preadmission requirements had been met.

(2) In cases of noncompliance with preadmission authorization requirements, institutional payment will be reduced by the amount attributable to the days of services without the appropriate certification up to a maximum of five days of services. In cases in which payment is determined on a prospectively set per-discharge basis (such as the DRG-based payment system), the reduction shall be \$500 for each day of services provided without the appropriate preauthorization, up to a maximum of five days of services.

(3) For purposes of paragraph A.12.b.(2) of this chapter, a day of services without the appropriate preauthorization is any day of services provided prior to:

(a) the receipt of an authorization; or

(b) the effective date of an authorization subsequently received.

(4) Services for which payment is disallowed under paragraph A.12.b.(2) of this chapter may not be billed to the patient (or the patient's family).

13. Implementing instructions. The Director, OCHAMPUS, or a designee, shall issue policies, instructions, procedures, guidelines, standards, or criteria as may be necessary to implement the intent of this Regulation.

B. INSTITUTIONAL BENEFITS

1. General. Services and supplies provided by an institutional provider authorized as set forth in Chapter 6 of this Regulation may be cost-shared only when such services or supplies (i) are otherwise authorized by this Regulation; (ii) are medically necessary; (iii) are ordered, directed, prescribed, or delivered by an OCHAMPUS-authorized individual professional provider as set forth in Chapter 6 of this Regulation or by an employee of the authorized institutional provider who is otherwise eligible to be a CHAMPUS authorized individual professional provider; (iv) are delivered in accordance with generally accepted norms for clinical practice in the United States; (v) meet established quality standards; and (vi) comply with applicable definitions, conditions, limitations, exceptions, or exclusions as otherwise set forth in this Regulation.

a. Billing practices. To be considered for benefits under this section B., covered services and supplies must be provided and billed for by a hospital or other authorized institutional provider. Such billings must be fully itemized and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. In the case of continuous care, claims shall be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor or, on a participating basis, directly by the facility on behalf of the beneficiary (refer to Chapter 7).

authorized institution is called in specifically to care for a single patient (individual nursing) or more than one patient (group nursing), whether the patient is billed for the nursing services directly or through the hospital or other institution, such services constitute private duty (special) nursing services and are not eligible for benefits under this paragraph (the provisions of paragraph C.2.o. of this chapter would apply).

c. ICU. An ICU is a special segregated unit of a hospital in which patients are concentrated, by reason of serious illness, usually without regard to diagnosis. Special lifesaving techniques and equipment are available regularly and immediately within the unit, and patients are under continuous observation by a nursing staff specially trained and selected for the care of this type of patient. The unit is maintained on a continuing, rather than an intermittent or temporary, basis. It is not a postoperative recovery room or a postanesthesia room. In some large or highly specialized hospitals, the ICUs may be refined further for special purposes, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery. For purposes of CHAMPUS, these specialized units would be considered ICUs if they otherwise conformed to the definition of an ICU.

d. Treatment rooms. Standard treatment rooms include emergency rooms, operating rooms, recovery rooms, special treatment rooms, and hyperbaric chambers and all related necessary medical staff and equipment. To be recognized for purposes of CHAMPUS, treatment rooms must be so designated and maintained by the hospital or other authorized institution on a continuing basis. A treatment room set up on an intermittent or temporary basis would not be so recognized.

e. Drugs and medicines. Drugs and medicines are included as a supply of a hospital or other authorized institution only under the following conditions:

- (1) They represent a cost to the facility rendering treatment;
- (2) They are furnished to a patient receiving treatment, and are related directly to that treatment; and
- (3) They are ordinarily furnished by the facility for the care and treatment of inpatients.

f. Durable medical equipment, medical supplies, and dressings. Durable medical equipment, medical supplies, and dressings are included as a supply of a hospital or other authorized institution only under the following conditions:

- (1) If ordinarily furnished by the facility for the care and treatment of patients; and
- (2) If specifically related to, and in connection with, the condition for which the patient is being treated; and
- (3) If ordinarily furnished to a patient for use in the hospital or other authorized institution (except in the case of a temporary or disposable item); and

(4) Use of durable medical equipment is limited to those items provided while the patient is an inpatient. If such equipment is provided for use on an outpatient basis, the provisions of section D. of this chapter apply.

g. Transitional use items. Under certain circumstances, a temporary or disposable item may be provided for use beyond an inpatient stay, when such item is necessary medically to permit or facilitate the patient's departure from the hospital or other authorized institution, or which may be required until such time as the patient can obtain a continuing supply; or it would be unreasonable or impossible from a medical standpoint to discontinue the patient's use of the item at the time of termination of his or her stay as an inpatient.

h. Anesthetics and oxygen. Anesthetics and oxygen and their administration are considered a service or supply if furnished by the hospital or other authorized institution, or by others under arrangements made by the facility under which the billing for such services is made through the facility.

6. Inpatient mental health services. Inpatient mental health services are those services furnished by institutional and professional providers for treatment of a nervous or mental disorder (as defined in Chapter 2) to a patient admitted to a CHAMPUS-authorized acute care general hospital; a psychiatric hospital; or, unless otherwise exempted, a special institutional provider.

a. Criteria for determining medical or psychological necessity. In determining the medical or psychological necessity of acute inpatient mental health services, the evaluation conducted by the Director, OCHAMPUS (or designee) shall consider the appropriate level of care for the patient, the intensity of services required by the patient, and the availability of that care. The purpose of such acute inpatient care is to stabilize a life-threatening or severely disabling condition within the context of a brief, intensive model of inpatient care in order to permit management of the patient's condition at a less intensive level of care. Such care is appropriate only if the patient requires services of an intensity and nature that are generally recognized as being effectively and safely provided only in an acute inpatient hospital setting. In addition to the criteria set forth in this paragraph B.6. of this chapter, additional evaluation standards, consistent with such criteria, may be adopted by the Director, OCHAMPUS (or designee). Acute inpatient care shall not be considered necessary unless the patient needs to be observed and assessed on a 24-hour basis by skilled nursing staff, and/or requires continued intervention by a multidisciplinary treatment team; and in addition, at least one of the following criteria is determined to be met:

- (1) Patient poses a serious risk of harm to self and/or others.
- (2) Patient is in need of high dosage, intensive medication or somatic and/or psychological treatment, with potentially serious side effects.
- (3) Patient has acute disturbances of mood, behavior, or thinking.

(4) For patients in care at the time the inpatient limit is reached, a waiver must be requested prior to the limit. For patients being readmitted after having received 30 or 45 days in the fiscal year, the waiver review will be conducted at the time of the preadmission authorization.

d. Acute care day limits do not apply to services provided under the Program for the Handicapped (Chapter 5 of this Regulation) or services provided as partial hospitalization care.

10. Psychiatric partial hospitalization services.

a. In general. Partial hospitalization services are those services furnished by a CHAMPUS-authorized partial hospitalization program and authorized mental health providers for the active treatment of a mental disorder. All services must follow a medical model and vest patient care under the general direction of a licensed psychiatrist employed by the partial hospitalization center to ensure medication and physical needs of all the patients are considered. The primary or attending provider must be a CHAMPUS authorized mental health provider, operating within the scope of his/her license. These categories include physicians, clinical psychologists, certified psychiatric nurse specialists, clinical social workers, marriage and family counselors, pastoral counselors and mental health counselors. Partial hospitalization services are covered as a basic program benefit only if they are provided in accordance with this paragraph B.10. of this chapter.

b. Criteria for determining medical or psychological necessity of psychiatric partial hospitalization services. Psychiatric partial hospitalization services will be considered necessary only if all of the following conditions are present:

(1) The patient is suffering significant impairment from a mental disorder (as defined in Chapter 2) which interferes with age appropriate functioning.

(2) The patient is unable to maintain himself or herself in the community, with appropriate support, at a sufficient level of functioning to permit an adequate course of therapy exclusively on an outpatient basis (but is able, with appropriate support, to maintain a basic level of functioning to permit partial hospitalization services and presents no substantial imminent risk of harm to self or others).

(3) The patient is in need of crisis stabilization, treatment of partially stabilized mental health disorders, or services as a transition from an inpatient program.

(4) The admission into the partial hospitalization program is based on the development of an individualized diagnosis and treatment plan expected to be effective for that patient and permit treatment at a less intensive level.

c. Preauthorization and concurrent review requirements. All preadmission authorization and concurrent review requirements and procedures applicable to acute mental health inpatient hospital care in paragraphs A.12. and B. of this chapter are applicable to the partial hospitalization program.

except that the criteria for considering medical or psychological necessity shall be those set forth in paragraph B.10.b. of this chapter, and no emergency admissions will be recognized.

d. Institutional benefits limited to 60 days. Benefits for institutional services for partial hospitalization are limited to 60 treatment days (whether a full day or partial day program) in a fiscal year or in an admission. This limit may be extended by waiver.

e. Waiver of the 60-day partial hospitalization program limit. The Director, OCHAMPUS (or designee) may, in special cases, waive the 60-day partial hospitalization benefit and authorize payment for care beyond the 60-day limit.

(1) The criteria for waiver are set forth in paragraph B.10.b. of this chapter. In applying these criteria in the context of waiver request review, special emphasis is placed on determining whether additional days of partial hospitalization are medically/psychologically necessary to complete essential elements of the treatment plan prior to discharge. Consideration is also given in cases in which a patient exhibits well-documented new symptoms or maladaptive behaviors which have appeared in the partial hospitalization setting requiring significant revisions to the treatment plan.

(2) The clinician responsible for the patient's care is responsible for documenting the need for additional days and must establish an estimated length of stay beyond the date of the 60-day limit. There must be evidence of a coherent and specific plan for assessment, intervention and reassessment that reasonably can be accomplished within the time frame of the additional days of coverage requested under the waiver provisions.

(3) For patients in care at the time the partial hospitalization program limit is reached, a waiver must be requested prior to the limit. For patients being readmitted after having received 60 days in the fiscal year, the waiver review will be conducted at the time of the preadmission authorization.

f. Services and supplies. The following services and supplies are included in the per diem rate approved for an authorized partial hospitalization program:

(1) Board. Includes use of the partial hospital facilities such as food service, supervised therapeutically constructed recreational and social activities, and other general services as considered appropriate by the Director, OCHAMPUS, or a designee.

(2) Patient assessment. Includes the assessment of each individual accepted by the facility, and must, at a minimum, consist of a physical examination; psychiatric examination; psychological assessment; assessment of physiological, biological and cognitive processes; developmental assessment; family history and assessment; social history and assessment; educational or vocational history and assessment; environmental assessment; and recreational/activities assessment. Assessments conducted within 30 days prior to admission to a partial program may be used if approved and deemed adequate to permit treatment planning by the partial hospital program.

(3) Psychological testing.

(4) Treatment services. All services, supplies, equipment and space necessary to fulfill the requirements of each patient's individualized diagnosis and treatment plan (with the exception of the five psychotherapy sessions per week which may be allowed separately for individual or family psychotherapy based upon the provisions of B.10.g. of this chapter.) All mental health services must be provided by a CHAMPUS authorized individual professional provider of mental health services. [Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate but the individual must work under the clinical supervision of a fully qualified mental health provider employed by the PHP.]

g. Social services required. The facility must provide an active social services component which assures the patient appropriate living arrangements after treatment hours, transportation to and from the facility, arrangement of community based support services, referral of suspected child abuse to the appropriate state agencies, and effective after care arrangements, at a minimum.

h. Educational services required. Programs treating children and adolescents must ensure the provision of a state certified educational component which assures that patients do not fall behind in educational placement while receiving partial hospital treatment. CHAMPUS will not fund the cost of educational services separately from the per diem rate. The hours devoted to education do not count toward the therapeutic half or full day program.

i. Family therapy required. The facility must ensure the provision of an active family therapy treatment component which assures that each patient and family participate at least weekly in family therapy provided by the institution and rendered by a CHAMPUS authorized individual professional provider of mental health services. There is no acceptable substitute for family therapy. An exception to this requirement may be granted on a case-by-case basis by the Director, OCHAMPUS, or designee, only if family therapy is clinically contraindicated.

j. Professional mental health benefits limited. Professional mental health benefits are limited to a maximum of one session (60 minutes individual, 90 minutes family) per authorized treatment day not to exceed five sessions in any calendar week. These may be billed separately from the partial hospitalization per diem rate only when rendered by an attending, CHAMPUS-authorized mental health professional who is not an employee of, or under contract with, the partial hospitalization program for purposes of providing clinical patient care.

k. Non-mental health related medical services. Separate billing will be allowed for otherwise covered, non-mental health related medical services.

C. PROFESSIONAL SERVICES BENEFIT

1. General. Benefits may be extended for those covered services described in this section C., that are provided in accordance with good medical practice and established standards of quality by physicians or other authorized individual professional providers, as set forth in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, exceptions, limitations, or exclusion as may be otherwise set forth

in this or other chapters of this Regulation. Except as otherwise specifically authorized, to be considered for benefits under this section C., the described services must be rendered by a physician, or prescribed, ordered, and referred medically by a physician to other authorized individual professional providers. Further, except under specifically defined circumstances, there should be an attending physician in any episode of care. (For example, certain services of a clinical psychologist are exempt from this requirement. For these exceptions, refer to Chapter 6.)

a. Billing practices. To be considered for benefits under this section C., covered professional services must be performed personally by the physician or other authorized individual professional provider, who is other than a salaried or contractual staff member of a hospital or other authorized institution, and who ordinarily and customarily bills on a fee-for-service basis for professional services rendered. Such billings must be itemized fully and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. For continuing professional care, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor, or directly by the physician or other authorized individual professional provider on behalf of a beneficiary (refer to Chapter 7 of this Regulation).

b. Services must be related. Covered professional services must be rendered in connection with and directly related to a covered diagnosis or definitive set of symptoms requiring medically necessary treatment.

2. Covered services of physicians and other authorized individual professional providers

a. Surgery. Surgery means operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and the following procedures:

- Bronchoscopy
- Laryngoscopy
- Thoracoscopy
- Catheterization of the heart
- Arteriograph thoracic lumbar
- Esophagoscopy
- Gastrosocopy
- Proctoscopy
- Sigmoidoscopy
- Peritoneoscopy
- Cystoscopy
- Colonoscopy
- Upper G.I. panendoscopy
- Encephalograph
- Myelography
- Discography
- Visualization of intracranial aneurysm by intracarotid injection of dye, with exposure of carotid artery, unilateral

1. Private duty (special) nursing. Benefits are available for the skilled nursing services rendered by a private duty (special) nurse to a beneficiary requiring intensive skilled nursing care that can only be provided with the technical proficiency and scientific skills of an R.N. The specific skilled nursing services being rendered are controlling, not the condition of the patient or the professional status of the private duty (special) nurse rendering the services.

(1) Inpatient private duty (special) nursing services are limited to those rendered to an inpatient in a hospital that does not have an ICU. In addition, under specified circumstances, private duty (special) nursing in the home setting also is covered.

(2) The private duty (special) nursing care must be ordered and certified to be medically necessary by the attending physician.

(3) The skilled nursing care must be rendered by a private duty (special) nurse who is neither a member of the immediate family nor is a member of the beneficiary's household.

[RESERVED]

(4) Private duty (special) nursing care does not, except incidentally, include providing services that provide or support primarily the essentials of daily living or acting as a companion or sitter.

(5) If the private duty (special) nursing care services being performed are primarily those that could be rendered by the average adult with minimal instruction or supervision, the services would not qualify as covered private duty (special) nursing services, regardless of whether performed by an R.N., regardless of whether or not ordered and certified to by the attending physician, and regardless of the condition of the patient.

(6) In order for such services to be considered for benefits, a private duty (special) nurse is required to maintain detailed daily nursing notes, whether the case involves inpatient nursing service or nursing services rendered in the home setting.

(7) Claims for continuing private duty (special) nursing care shall be submitted at least every 30 days. Each claim will be reviewed and the nursing care evaluated whether it continues to be appropriate and eligible for benefits.

(8) In most situations involving private duty (special) nursing care rendered in the home setting, benefits will be available only for a portion of the care, that is, providing benefits only for that time actually required to perform medically necessary skilled nursing services. If full-time private duty (special) nursing services are engaged, usually for convenience or to provide personal services to the patient, CHAMPUS benefits are payable only for that portion of the day during which skilled nursing services are rendered, but in no event is less than 1 hour of nursing care payable in any 24-hour period during which skilled nursing services are determined to have been rendered. Such situations often are better accommodated through the use of visiting nurses. This allows the personal services that are not coverable by CHAMPUS to be obtained at lesser cost from other than an R.N. Skilled nursing services provided by visiting nurses are covered under CHAMPUS.

NOTE: When the services of an R.N. are not available, benefits may be extended for the otherwise covered services of a L.P.N. or L.V.N.

D. OTHER BENEFITS

1. General. Benefits may be extended for the allowable charge of those other covered services and supplies described in this section D., which are provided in accordance with good medical practice and established standards of quality by those other authorized providers described in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, limitations, or exclusions as otherwise may be set forth in this or other chapters of this Regulation. To be considered for benefits under this section D., the described services or supplies must be prescribed and ordered by a physician. Other authorized individual professional providers acting within their scope of licensure may also prescribe and order these services and supplies unless otherwise specified in this section D. For example, durable medical equipment and cardiorespiratory monitors can only be ordered by a physician.

2. Billing practices. To be considered for benefits under this Section D., covered services and supplies must be provided and billed for by an authorized provider as set forth in Chapter 6 of this Regulation. Such billing must be itemized fully and described sufficiently, even when CHAMPUS payment is determined under the CHAMPUS DRG-based payment system, so that CHAMPUS can determine whether benefits are authorized by this Regulation. Except for claims subject to the CHAMPUS DRG-based payment system, whenever continuing charges are involved, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days (monthly) either by the beneficiary or sponsor or directly by the provider. For claims subject to the CHAMPUS DRG-based payment system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

3. Other covered services and supplies

a. Blood. If whole blood or plasma (or its derivatives) are provided and billed for by an authorized institution in connection with covered treatment, benefits are extended as set forth in section B. of this chapter. If blood is billed for directly to a beneficiary, benefits may be extended under this section D. in the same manner as a medical supply.

b. Durable medical equipment

(1) Scope of benefit. Subject to the exceptions in paragraphs (2) and (3) below, only durable medical equipment (DME) which is ordered by a physician for the specific use of the beneficiary, and which complies with the definition of "Durable Medical Equipment" in Chapter 2 of this Regulation, and which is not otherwise excluded by this Regulation qualifies as a Basic Program benefit.

(2) Cardiorespiratory monitor exception.

(a) When prescribed by a physician who is otherwise eligible as a CHAMPUS individual professional provider, or who is on active duty with a United States Uniformed Service, an electronic cardiorespiratory monitor, including technical support necessary for the proper use of the monitor, may be cost-shared as durable medical equipment when supervised by the prescribing physician for in-home use by:

1 An infant beneficiary who has had an apparent life-threatening event, as defined in guidelines issued by the Director, OCHAMPUS, or a designee, or,

2 An infant beneficiary who is a subsequent or multiple birth biological sibling of a victim of sudden infant death syndrome (SIDS), or,

3 An infant beneficiary whose birth weight was 1,500 grams or less, or,

4 An infant beneficiary who is a pre-term infant with pathologic apnea, as defined in guidelines issued by the Director, OCHAMPUS, or a designee, or,

(3) Newborn patient in his or her own right. When a newborn infant remains as an inpatient in his or her own right (usually after the mother is discharged), the newborn child becomes the beneficiary and patient and the extended inpatient stay becomes a separate inpatient admission. In such a situation, a new, separate inpatient cost-sharing amount is applied. If a multiple birth is involved (such as twins or triplets) and two or more newborn infants become patients in their own right, a separate inpatient cost-sharing amount must be applied to the inpatient stay for each newborn child who has remained as an inpatient in his or her own right.

c. Outpatient cost-sharing. Dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of 20 percent of the CHAMPUS-determined allowable cost or charge beyond the annual fiscal year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

d. Ambulatory surgery. Notwithstanding the above provisions pertaining to outpatient cost-sharing, dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of \$25 for surgical care that is authorized and received while in an outpatient status and that has been designated in guidelines issued by the Director, OCHAMPUS, or a designee.

e. Psychiatric partial hospitalization services. Institutional and professional services provided under the psychiatric partial hospitalization program authorized by paragraph B.10. of this chapter shall be cost-shared as inpatient services.

3. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees. CHAMPUS beneficiary liability set forth for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. The annual fiscal year deductible for otherwise covered outpatient services or supplies provided retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees, is the same as the annual fiscal year outpatient deductible applicable to dependents of active duty members of rank E-5 or above (refer to paragraph F.2.a.(1) or (2) of this chapter).

b. Inpatient cost-sharing. Cost-sharing amounts for inpatient services shall be as follows:

(1) Services subject to the CHAMPUS DRG-based payment system. The cost-share shall be the lesser of an amount calculated by multiplying a per diem amount for each day of the hospital stay except the day of discharge or 25 percent of the hospital's billed charges. The per diem amount shall be calculated so that total cost-sharing amounts for these beneficiaries is equivalent to 25 percent of the CHAMPUS-determined allowable costs for covered services or supplies provided on an inpatient basis by authorized providers. The per diem amount shall be published annually by CHAMPUS.

(2) Services subject to the mental health per diem payment system. The cost-share is dependent upon whether the hospital is paid a hospital-specific per diem or a regional per diem under the provisions of subsection A.2. of Chapter 14. With respect to care paid for on the basis of a hospital-specific per diem,

the cost-share shall be 25% of the hospital-specific per diem amount. For care paid for on the basis of a regional per diem, the cost share shall be the lower of a fixed daily amount or 25% of the hospital's billed charges. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25% of total payments under the mental health per diem payment system. This fixed daily amount shall be updated annually and published in the Federal Register along with the per diems published pursuant to subparagraph A.2.d.(2) of Chapter 14.

(3) Other services. For services exempt from the CHAMPUS DRG-based payment system and the CHAMPUS mental health per diem payment system and services provided by institutions other than hospitals, the cost-share shall be 25% of the CHAMPUS-determined allowable charges.

c. Outpatient cost-sharing. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees are responsible for payment of 25 percent of the CHAMPUS-determined allowable costs or charges beyond the annual fiscal year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

d. Psychiatric partial hospitalization services. Institutional and professional services provided under the psychiatric partial hospitalization program authorized by paragraph B.10. of this chapter shall be cost-shared as inpatient services.

4. Former spouses. CHAMPUS beneficiary liability set forth for former spouses eligible under the provisions of paragraph B.2.b. of Chapter 3 is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. An eligible former spouse is responsible for the payment of the first \$150 of the CHAMPUS-determined reasonable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year. (Except for services received prior to April 1, 1991, the deductible amount is \$50.00). The former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of any CHAMPUS-eligible children.

b. Inpatient cost-sharing. Eligible former spouses are responsible for the payment of cost-sharing amounts the same as those required for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.

c. Outpatient cost-sharing. Eligible former spouses are responsible for payment of 25 percent of the CHAMPUS-determined reasonable costs or charges beyond the annual fiscal year deductible amount for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

5. Cost-Sharing under the Military-Civilian Health Services Partnership Program. Cost-sharing is dependent upon the type of partnership program entered into, whether external or internal. (See section P. of Chapter 1, for general requirements of the Military-Civilian Health Services Partnership Program.)

a. External Partnership Agreement. Authorized costs associated with the use of the civilian facility will be financed through CHAMPUS under the normal cost-sharing and reimbursement procedures applicable under CHAMPUS.

CHAPTER 6
AUTHORIZED PROVIDERS

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NOTE: An infirmary in a boarding school also may qualify under this provision, subject to review and approval by the Director, OCHAMPUS, or a designee.

j. Other special institutional providers.

(1) General

(a) Care provided by certain special institutional providers (on either an inpatient or outpatient basis), may be cost-shared by CHAMPUS under specified circumstances and only if the provider is specifically identified in this paragraph B.4.j.

1 The course of treatment is prescribed by a doctor of medicine or osteopathy.

2 The patient is under the supervision of a physician during the entire course of the inpatient admission or the outpatient treatment.

3 The type and level of care and service rendered by the institution are otherwise authorized by this Regulation.

4 The facility meets all licensing or other certification requirements that are extant in the jurisdiction in which the facility is located geographically.

5 Is other than a nursing home, intermediate care facility, home for the aged, halfway house, or other similar institution.

6 Is accredited by the JCAHO or other CHAMPUS-approved accreditation organization, if an appropriate accreditation program for the given type of facility is available. As future accreditation programs are developed to cover emerging specialized treatment programs, such accreditation will be a prerequisite to coverage by CHAMPUS for services provided by such facilities.

(b) To ensure that CHAMPUS beneficiaries are provided quality care at a reasonable cost when treated by a special institutional provider, the Director, OCHAMPUS, or a designee, will retain the right to:

1 Require prior approval of all admissions to special institutional providers.

2 Set appropriate standards for special institutional providers in addition to or in the absence of JCAHO accreditation.

3 Monitor facility operations and treatment programs on a continuing basis and conduct onsite inspections on a scheduled and unscheduled basis.

4 Negotiate agreements of participation.

5 Terminate approval of a case when it is ascertained that a departure from the facts upon which the admission was based originally has occurred.

6 Declare a special institutional provider not eligible for CHAMPUS payment if that facility has been found to have engaged in fraudulent or deceptive practices.

(c) In general, the following disclaimers apply to treatment by special institutional providers:

1 Just because one period or episode of treatment by a facility has been covered by CHAMPUS may not be construed to mean that later episodes of care by the same or similar facility will be covered automatically.

2 The fact that one case has been authorized for treatment by a specific facility or similar type of facility may not be construed to mean that similar cases or later periods of treatment will be extended CHAMPUS benefits automatically.

(2) Types of providers. The following is a list of facilities that have been designated specifically as special institutional providers.

(a) Free-standing ambulatory surgical centers. Care provided by freestanding ambulatory surgical centers may be cost-shared by CHAMPUS under the following circumstances:

1 The treatment is prescribed and supervised by a physician.

2 The type and level of care and services rendered by the center are otherwise authorized by this Regulation.

3 The center meets all licensing or other certification requirements of the jurisdiction in which the facility is located.

4 The center is accredited by the JCAHO, the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), or such other standards as authorized by the Director, OCHAMPUS.

5 A childbirth procedure provided by a CHAMPUS-approved free-standing ambulatory surgical center shall not be cost-shared by CHAMPUS unless the surgical center is also a CHAMPUS-approved birthing center institutional provider as established by the birthing center provider certification requirement of this Regulation.

(b) PFTH facilities. Special institutional providers also include facilities that seek approval to provide care authorized under the PFTH. (Refer to Chapter 5 of this Regulation.)

(c) Substance use disorder rehabilitation facilities. In order to be authorized under CHAMPUS as a provider of substance use detoxification, rehabilitative services, outpatient treatment, and family therapy, substance use rehabilitation facilities, both freestanding facilities and hospital-based facilities, shall operate primarily for the purpose of providing treatment of substance use disorders (on either an inpatient (including partial care) or an outpatient basis) and shall meet the following criteria:

1 The course of treatment shall be prescribed by and supervised by a qualified mental health provider (refer to Chapter 4, paragraph C.3.i.) practicing within the scope of his or her license. When indicated by the patient's physical status, the patient shall be under the general supervision of a physician.

2 The type and level of care provided by the facility are otherwise authorized by this Regulation.

3 The facility shall meet all licensing and other certification requirements of the jurisdiction in which the facility is located.

4 The facility shall be accredited by and shall remain in substantial compliance with standards issued by either the Joint Commission on Accreditation of Healthcare Organizations under the Consolidated Standards Manual, or the Commission Accreditation of Rehabilitation Facilities (CARF) or shall meet such other requirements as the Director, OCHAMPUS, finds necessary in the interest of the health and safety of the individuals who are furnished services in the facility.

5 The facility shall have entered into a participation agreement with OCHAMPUS within which the facility agrees, in part, to:

a Accept payment for its services based on an allowable-cost rate acceptable to the Director, OCHAMPUS, or such other method as determined by the Director, OCHAMPUS;

b Furnish OCHAMPUS with cost data certified to by an independent accounting firm or other agency as authorized by the Director, OCHAMPUS;

c Accept the CHAMPUS-determined rate as payment in full and to collect from the CHAMPUS beneficiary those amounts that represent the beneficiary's liability, as defined in Chapter 4, and charges for services and supplies that are not a benefit of CHAMPUS;

d Make all reasonable efforts acceptable to the Director, OCHAMPUS, to collect those amounts which represent the beneficiary's liability, as defined in Chapter 4;

e Permit access by the Director, OCHAMPUS, to clinical records of CHAMPUS beneficiaries and to the financial and organizational records of the facility;

f Comply with the provisions of Chapter 8, and to submit claims first to all health insurance coverage to which the beneficiary is entitled that is primary to CHAMPUS.

6 The substance use rehabilitation facility shall not be considered to be a CHAMPUS-authorized provider and CHAMPUS benefits shall not be paid for services provided by the substance use rehabilitation facility until the date the participation agreement is signed by the Director, OCHAMPUS, or a designee.

7 The substance use rehabilitation facility is not designated by the Health Care Financing Administration as an alcohol and drug abuse hospital for purposes of applicability of the Medicare prospective payment system.

8 At a minimum, medical records will be maintained in accordance with the JCAHO Consolidated Standard Manual for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities and Facilities Serving the Mentally Retarded, along with the requirements set forth in Section 199.7(b)(3). The alcohol rehabilitation facility is responsible for assuring that patient services and all treatment are accurately documented and completed in a timely manner.

k. Birthing centers. A birthing center is a freestanding or institution-affiliated outpatient maternity care program which principally provides a planned course of outpatient prenatal care and outpatient childbirth service limited to low-risk pregnancies; excludes care for high-risk pregnancies; limits childbirth to the use of natural childbirth procedures; and provides immediate newborn care.

(1) Certification requirements. A birthing center which meets the following criteria may be designated as an authorized CHAMPUS institutional provider:

(a) The predominant type of service and level of care rendered by the center is otherwise authorized by this Regulation.

(b) The center is licensed to operate as a birthing center where such license is available, or is specifically licensed as a type of ambulatory health care facility where birthing center specific license is not available, and meets all applicable licensing or certification requirements that are extant in the state, county, municipality, or other political jurisdiction in which the center is located.

(i) Professional staff. The center's professional staff is legally and professionally qualified for the performance of their professional responsibilities.

(j) Medical records. The center maintains full and complete written documentation of the services rendered to each woman admitted and each newborn delivered. A copy of the informed consent document required by subparagraph (c), above, which contains the original signature of the CHAMPUS beneficiary, signed and dated at the time of admission, must be maintained in the medical record of each CHAMPUS beneficiary admitted.

(k) Quality assurance. The center has an organized program for quality assurance which includes, but is not limited to, written procedures for regularly scheduled evaluation of each type of service provided, of each mother or newborn transferred to a hospital, and of each death within the facility.

(l) Governance and administration. The center has a governing body legally responsible for overall operation and maintenance of the center and a full-time employee who has authority and responsibility for the day-to-day operation of the center.

1. Psychiatric partial hospitalization programs. Psychiatric partial hospitalization programs must be either a distinct part of an otherwise authorized institutional provider or a freestanding program. The treatment program must be under the general direction of a psychiatrist employed by the partial hospitalization program to ensure medication and physical needs of all the patients are considered. The primary or attending provider must be a CHAMPUS authorized mental health provider, operating within the scope of his/her license. These categories include physicians, clinical psychologists, certified psychiatric nurse specialists, clinical social workers, marriage and family counselors, pastoral counselors and mental health counselors. CHAMPUS reimbursement is limited to programs complying with all requirements of Chapter 4, paragraph B.10. In addition, in order for a partial hospitalization program (PHP) to be authorized, the PHP shall comply with the following requirements:

(1) The PHP shall comply with the CHAMPUS Standards for Partial Hospitalization Programs and Facilities, as promulgated by the Director, OCHAMPUS.

(2) The PHP shall be specifically accredited by and remain in substantial compliance with standards issued by the Joint Commission on Accreditation of Healthcare Organizations under the Mental Health Manual (formerly the Consolidated Standards). NOTE: A one-time grace period is being allowed not to exceed April 1, 1994 for this provision only if the provider is already accredited under the JCAHO hospital standards. The provider must agree not to accept any new admissions for CHAMPUS patients for care beyond April 1, 1994, if accreditation and substantial compliance with the Mental Health Manual standards have not been obtained by that date.

(3) The PHP shall be licensed as a partial hospitalization program to provide PHP services within the applicable jurisdiction in which it operates.

(4) The PHP shall accept the CHAMPUS-allowable partial hospitalization program rate, as provided in Chapter 14, paragraph A.2.i., as payment in full for services provided.

(5) The PHP shall comply with all requirements of this section applicable to institutional providers generally concerning preauthorization, concurrent care review, claims processing, beneficiary liability, double coverage, utilization and quality review and other matters.

(6) The PHP must be fully operational and treating patients for a period of at least six months (with at least 30 percent minimum patient census) before an application for approval may be submitted. The PHP shall not be considered a CHAMPUS-authorized provider nor may any CHAMPUS benefits be paid to the facility for any services provided prior to the date the facility is approved by the Director, OCHAMPUS, or designee.

(7) All mental health services must be provided by a CHAMPUS-authorized mental health provider. [Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate but the individual must work under the clinical supervision of a fully qualified mental health provider employed by the PHP.] All other program services shall be provided by trained, licensed staff.

(8) The PHP shall ensure the provision of an active family therapy treatment component which assures that each patient and family participate at least weekly in family therapy provided by the institution and rendered by a CHAMPUS authorized mental health provider.

(9) The PHP must have a written agreement with at least one backup CHAMPUS-authorized hospital which specifies that the hospital will accept any and all CHAMPUS beneficiaries transferred for emergency mental health or medical/surgical care. The PHP must have a written emergency transport agreement with at least one ambulance company which specifies the estimated transport time to each backup hospital.

(10) The PHP shall enter into a participation agreement with the Director, OCHAMPUS, which shall include but which shall not be limited to the following provisions:

(a) The PHP agrees not to bill the beneficiary for services in excess of the cost-share or services for which payment is disallowed for failure to comply with requirements for preauthorization or concurrent care review.

(b) The PHP agrees not to bill the beneficiary for services excluded on the basis of Chapter 4, paragraphs G.1. (not medically necessary), G.3. (inappropriate level of care) or G.7. (custodial care), unless the beneficiary has agreed in writing to pay for the care, knowing the specific care in question had been determined noncovered by CHAMPUS. (A general statement signed at admission as to financial liability does not fulfill this requirement.)

C. INDIVIDUAL PROFESSIONAL PROVIDERS OF CARE

1. General. Individual professional providers of care are those providers who bill for their services on a fee-for-service basis and are not employed or

contracted with by an institutional provider. This category also includes those individuals who have formed professional corporations or associations qualifying as a domestic corporation under section 301.7701-5 of the Internal Revenue Service Regulations (reference (cc)). Such individual professional providers must be licensed or certified by the local licensing or certifying agency for the jurisdiction in which the care is provided; or in the absence of state licensure/certification, be a member of or demonstrate eligibility for full clinical membership in, the appropriate national or professional certifying association that sets standards for the profession of which the provider is a member. Services provided must be in accordance with good medical practice and prevailing standards of quality of care and within recognized utilization norms.

a. Licensing/Certification required, scope of license. Otherwise covered services shall be cost-shared only if the individual professional provider holds a current, valid license or certification to practice his or her profession in the jurisdiction where the service is rendered. Licensure/certification must be at the full clinical practice level. The services provided must be within the scope of the license, certification or other legal authorization. Licensure or certification is required to be a CHAMPUS authorized provider if offered in the jurisdiction where the service is rendered, whether such licensure or certification is required by law or provided on a voluntary basis. The requirement also applies for those categories of providers that would otherwise be exempt by the state because the provider is working in a non-profit, state-owned or church setting. Licensure/certification is mandatory for a provider to become a CHAMPUS-authorized provider.

b. Monitoring required. The Director, OCHAMPUS, or a designee, shall develop appropriate monitoring programs and issue guidelines, criteria, or norms necessary to ensure that CHAMPUS expenditures are limited to necessary medical supplies and services at the most reasonable cost to the government and beneficiary. The Director, OCHAMPUS, or a designee, also will take such steps as necessary to deter overutilization of services.

c. Christian Science. Christian Science practitioners and Christian Science nurses are authorized to provide services under CHAMPUS. Inasmuch as they provide services of an extramedical nature, the general criteria outlined above do not apply to Christian Science services (refer to subparagraph C.3.d.(2), below, regarding services of Christian Science practitioners and nurses).

d. Physician referral and supervision. Physician referral and supervision is required for the services of paramedical providers as listed in subparagraph C.3.c.8. and for marriage and family counselors, pastoral counselors, and mental health counselors. Physician referral means that the physician must actually see the patient, perform an evaluation, and arrive at an initial diagnostic impression prior to referring the patient. Documentation is required of the physician's examination, diagnostic impression, and referral. Physician supervision means that the physician provides overall medical management of the case. The physician does not have to be physically located on the premises of the provider to whom the referral is made. Communication back to the referring physician is an indication of medical management.

e. Medical records: Individual professional providers must maintain adequate clinical records to substantiate that specific care was actually furnished, was medically necessary, and appropriate, and identify(ies) the individual(s) who provided the care. This applies whether the care is inpatient or outpatient. The minimum requirements for medical record documentation are set forth by the following:

- (1) The cognizant state licensing authority;
- (2) The Joint Commission on Accreditation of Healthcare Organizations, or other health care accreditation organizations as may be appropriate;
- (3) Standards of practice established by national medical organizations; and
- (4) This Regulation.

2. Interns and residents. Interns and residents may not be paid directly by CHAMPUS for services rendered to a beneficiary when their services are provided as part of their employment (either salaried or contractual) by a hospital or other institutional provider.

(a) Psychiatric admission evaluation report within 24 hours of admission.

(b) History and physical examination within 24 hours of admission; complete report documented within 72 hours for acute and residential programs and within 3 working days for partial programs.

(c) Individual and family therapy notes within 24 hours of procedure for acute, detoxification and Residential Treatment Center (RTC) programs and within 48 hours for partial programs.

(d) Preliminary treatment plan within 24 hours of admission.

(e) Master treatment plan within 5 calendar days of admission for acute care, 10 days for RTC care, 5 days for full-day partial programs and within 7 days for half-day partial programs.

(f) Family assessment report within 72 hours of admission for acute care and 7 days for RTC and partial programs.

(g) Nursing assessment report within 24 hours of admission.

(h) Nursing notes at the end of each shift for acute and detoxification programs; every ten visits for partial hospitalization; and at least once a week for RTCs.

(i) Daily physician notes for intensive treatment, detoxification, and rapid stabilization programs; twice per week for acute programs; and once per week for RTC and partial programs.

(j) Group therapy notes once per week.

(k) Ancillary service notes once per week.

NOTE: A pattern of failure to meet the above criteria may result in provider sanctions prescribed under Chapter 9 of the Regulation.

4. Double coverage information. When the CHAMPUS beneficiary is eligible for medical benefits coverage through another plan, insurance, or program, either private or Government, the following information must be provided:

a. Name of other coverage. Full name and address of double coverage plan, insurance, or program (such as Blue Cross, Medicare, commercial insurance, and state program).

b. Source of double coverage. Source of double coverage (such as employment, including retirement, private purchase, membership in a group, and law).

c. Employer information. If source of double coverage is employment, give name and address of employer.

d. Identification number. Identification number or group number of other coverage.

5. Right to additional information

a. As a condition precedent to the cost-sharing of benefits under this Regulation or pursuant to a review or audit, whether the review or audit is prospective, concurrent, or retroactive, OCHAMPUS or CHAMPUS contractors may request, and shall be entitled to receive, information from a physician or hospital or other person, institution, or organization (including a local, state, or Federal Government agency) providing services or supplies to the beneficiary for whom claims or requests for approval for benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, examination, diagnosis, treatment, or services and supplies furnished to a beneficiary and, as such, shall be necessary for the accurate and efficient administration of CHAMPUS benefits. This may include requests for copies of all medical records or documentation related to the episode of care. In addition, before a determination on a request for preauthorization or claim of benefits is made, a beneficiary, or sponsor, shall provide additional information relevant to the requested determination, when necessary. The recipient of such information shall hold such records confidential except when:

(1) Disclosure of such information is authorized specifically by the beneficiary;

(2) Disclosure is necessary to permit authorized governmental officials to investigate and prosecute criminal actions; or

(3) Disclosure is authorized or required specifically under the terms of DoD Directives 5400.7 and 5400.11, the Freedom of Information Act, and the Privacy Act (references (i), (j), and (k)) (refer to section M. of Chapter 1 of this Regulation).

b. For the purposes of determining the applicability of and implementing the provisions of Chapters 8 and 9, or any provision of similar purpose of any other medical benefits coverage or entitlement, OCHAMPUS or CHAMPUS fiscal intermediaries, without consent or notice to any beneficiary or sponsor, may release to or obtain from any insurance company or other organization, governmental agency, provider, or person, any information with respect to any beneficiary when such release constitutes a routine use duly published in the Federal Register in accordance with the Privacy Act.

c. Before a beneficiary's claim of benefits is adjudicated, the beneficiary or the provider(s) must furnish to CHAMPUS that information which is necessary to make the benefit determination. Failure to provide the requested

CHAPTER 14
PROVIDER REIMBURSEMENT METHODS

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notice in accordance with procedures established by the Director, OCHAMPUS, or a designee.

g. Leave days. CHAMPUS shall not pay for days where the patient is absent on leave from the specialty psychiatric hospital or unit. The hospital must identify these days when claiming reimbursement. CHAMPUS shall not count a patient's leave of absence as a discharge in determining whether a facility should be classified as a higher volume hospital pursuant to paragraph A.2.e. of this chapter.

h. Exemptions from the CHAMPUS mental health per diem payment system. The following providers and procedures are exempt from the CHAMPUS mental health per diem payment system.

(1) Non-specialty providers. Providers of inpatient care which are not either psychiatric hospitals or psychiatric specialty units as described in subparagraph A.2.a.(1) of this chapter are exempt from the CHAMPUS mental health per diem payment system. Such providers should refer to subsection A.1. of this chapter for provisions pertinent to the CHAMPUS DRG-based payment system.

(2) DRG 424. Admissions for operating room procedures involving a principal diagnosis of mental illness (services which group into DRG 424) are exempt from the per diem payment system. They will be reimbursed pursuant to the provisions of subsection A.3. of this chapter.

(3) Non-mental health services. Admissions for non-mental health procedures in specialty psychiatric hospitals and units are exempt from the per diem payment system. They will be reimbursed pursuant to the provisions of subsection A.3. of this chapter.

(4) Sole community hospitals. Any hospital which has qualified for special treatment under the Medicare prospective payment system as a sole community hospital and has not given up that classification is exempt.

(5) Hospitals outside the U.S. A hospital is exempt if it is not located in one of the 50 states, the District of Columbia or Puerto Rico.

i. Per diem payment for psychiatric partial hospitalization services.

(1) In general. Psychiatric partial hospitalization services authorized by Chapter 4, paragraph B.10. and provided by institutional providers authorized under Chapter 6, paragraph B.4.1., are reimbursed on the basis of prospectively determined, all-inclusive per diem rates. The per diem payment amount must be accepted as payment in full for all institutional services provided, including board, routine nursing services, ancillary services (includes art, music, dance, occupational and other such therapies), psychological testing and assessments, overhead and any other services for which the customary practice among similar providers is included as part of the institutional charges.

(2) Services which may be billed separately. The following services are not considered as included within the per diem payment amount and may be separately billed when provided by an authorized independent professional provider:

(a) Psychotherapy sessions not included.

Professional services provided by an authorized professional provider (who is not employed by or under contract with the partial hospitalization program) for purposes of providing clinical patient care to a patient in the partial hospitalization program are not included in the per diem rate. They may be separately billed. Professional mental health benefits are limited to a maximum of one session (60 minutes individual, 90 minutes family, etc.) per authorized treatment day not to exceed five sessions in any calendar week.

(b) Non-mental health related medical services.

Those services not normally included in the evaluation and assessment of a partial hospitalization program, non-mental health related medical services, may be separately billed when provided by an authorized independent professional provider. This includes ambulance services when medically necessary for emergency transport.

(3) Per diem rate. For any full day partial hospitalization program (minimum of 6 hours), the maximum per diem payment amount is 40 percent of the average inpatient per diem amount per case paid to both high and low volume psychiatric hospitals and units (as defined in Chapter 14, A.2.) by Federal census region during fiscal year 1990. The average will be based upon CHAMPUS claims processed to completion during the above period and updated to the current year using the same factors as used under the CHAMPUS mental health per diem reimbursement system (as described in Chapter 14, A.2.). A partial hospitalization program of less than 6 hours (with a minimum of three hours) will be paid a per diem rate of 75 percent of the rate for full-day program.

(4) Other requirements. No payment is due for leave days, for days in which treatment is not provided, or for days in which the duration of the program services was less than three hours.

3. Billed charges and set rates. The allowable costs for authorized care in all hospitals not subject to the CHAMPUS DRG-based payment system or the CHAMPUS mental health per diem payment system shall be determined on the basis of billed charges or set rates. Under this procedure the allowable costs may not exceed the lower of:

a. The actual charge for such service made to the general public;
or

b. The allowed charge applicable to the policyholders or subscribers of the CHAMPUS fiscal intermediary for comparable services under comparable circumstances, when extended to CHAMPUS beneficiaries by consent or agreement; or

c. The allowed charge applicable to the citizens of the community

or state as established by local or state regulatory authority, excluding title XIX of the Social Security Act or other welfare program, when extended to CHAMPUS beneficiaries by consent or agreement.

4. CHAMPUS discount rates. The CHAMPUS-determined allowable cost for authorized care in any hospital may be based on discount rates established under section I. of this chapter.

B. SKILLED NURSING FACILITIES (SNFs)

The CHAMPUS-determined allowable cost for reimbursement of a SNF shall be determined on the same basis as for hospitals which are not subject to the CHAMPUS DRG-based payment system.

C. REIMBURSEMENT FOR OTHER THAN HOSPITALS AND SNFs

The Director, OCHAMPUS, or a designee, shall establish such other methods of determining allowable cost or charge reimbursement for those institutions, other than hospitals and SNFs, as may be required.

D. REIMBURSEMENT OF FREESTANDING AMBULATORY SURGICAL CENTERS

Authorized care furnished by freestanding ambulatory surgical centers shall be reimbursed on the basis of the CHAMPUS-determined reasonable cost.

E. REIMBURSEMENT OF BIRTHING CENTERS

1. Reimbursement for maternity care and childbirth services furnished by an authorized birthing center shall be limited to the lower of the CHAMPUS established all-inclusive rate or the center's most-favored all-inclusive rate.

2. The all-inclusive rate shall include the following to the extent that they are usually associated with a normal pregnancy and childbirth: laboratory studies, prenatal management, labor management, delivery, post-partum management, newborn care, birth assistant, certified nurse-midwife professional services, physician professional services, and the use of the facility.

3. The CHAMPUS established all-inclusive rate is equal to the sum of the CHAMPUS area prevailing professional charge for total obstetrical care for a normal pregnancy and delivery and the sum of the average CHAMPUS allowable institutional charges for supplies, laboratory, and delivery room for a hospital inpatient normal delivery. The CHAMPUS established all-inclusive rate areas will coincide with those established for prevailing professional charges and will be updated concurrently with the CHAMPUS area prevailing professional charge database.

4. Extraordinary maternity care services, when otherwise authorized, may be reimbursed at the lesser of the billed charge or the CHAMPUS allowable charge.

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on a case-by-case basis if requested by the CHAMPUS beneficiary (or sponsor) involved. A decision by the Director to waive or not waive the limit in any particular case is not subject to the appeal and hearing procedures of Chapter 10., of this regulation.

b. Prevailing charge level.

(1) Beginning in calendar year 1992, the prevailing charge level shall be calculated on a national basis.

(2) The national prevailing charge level referred to in paragraph G.1.b.(1) of this section is the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period. The 80th percentile of charges shall be determined on the basis of statistical data and methodology acceptable to the Director, OCHAMPUS (or a designee).

(3) For purposes of paragraph G.1.b.(2) of this section, the base period shall be a period of 12 calendar months and shall be adjusted once a year, unless the Director, OCHAMPUS determines that a different period for adjustment is appropriate and publishes a notice to that effect in the Federal Register.

c. Appropriate charge level. Beginning in calendar year 1992, the appropriate charge level for each procedure is the product of the two-step process set forth in paragraphs G.1.(c)(1) and (2) of this Chapter. This process involves comparing the prior year's CMAC with the fully phased in Medicare fee. For years after the Medicare fee has been fully phased in, the comparison shall be to the current Medicare fee. For any particular procedure for which comparable Medicare fee and CHAMPUS data are unavailable, but for which alternative data are available that the Director, OCHAMPUS (or designee) determines provide a reasonable approximation of relative value or price, the comparison may be based on such alternative data.

(1) Step 1: procedures classified. All procedures are classified into one of three categories, as follows:

(a) Overpriced procedures. These are the procedures for which the prior year's national CMAC exceeds the Medicare fee.

(b) Other procedures. These are procedures subject to the allowable charge method that are not included in either the overpriced procedures group or the underpriced procedures group.

(c) Underpriced procedures. These are the procedures for which the prior year's national CMAC is less than the Medicare fee.

(2) Step 2: calculating appropriate charge levels. For each year, appropriate charge levels will be calculated by adjusting the prior year's CMAC as follows:

(a) For overpriced procedures, the appropriate charge level for each procedure shall be the prior year's CMAC, reduced by the lesser of: the percentage by which it exceeds the Medicare fee or fifteen percent.

(b) For other procedures, the appropriate charge level for each procedure shall be the same as the prior year's CMAC.

(c) For underpriced procedures, the appropriate charge level for each procedure shall be the prior year's CMAC, increased by the lesser of: the percentage by which it is exceeded by the Medicare fee or the Medicare Economic Index.

c. Special rule for cases in which the CHAMPUS appropriate charge was prematurely reduced. In any case in which a recalculation of the Medicare fee results in a Medicare rate higher than the CHAMPUS appropriate charge for a procedure that had been considered an overpriced procedure, the reduction in the CHAMPUS appropriate charge shall be restored up to the level of the recalculated Medicare rate.

d. Calculating CHAMPUS Maximum Allowable Charge levels for localities.

(1) In general. The national CHAMPUS Maximum Allowable Charge level for each procedure will be adjusted for localities using the same (or similar) geographical areas and the same geographic adjustment factors as are used for determining allowable charges under Medicare.

(2) Special locality-based phase-in provision.

(a) In general. Beginning with the recalculation of CMACs for calendar year 1993, the CMAC in a locality will not be less than 72.25 percent of the maximum charge level in effect for that locality on December 31, 1991. For recalculations of CMACs for calendar years after 1993, the CMAC in a locality will not be less than 85 percent of the CMAC in effect for that locality at the end of the prior calendar year.

(b) Exception. The special locality-based phase-in provision established by Section G.1.d.(2)(a) of this Chapter shall not be applicable in the case of any procedure code for which there were not CHAMPUS claims in the locality accounting for at least 50 services.

(3) Special locality-based waivers of reductions to assure adequate access to care. Beginning with the recalculation of CMACs for calendar year 1993, in the case of any procedure classified as an overpriced procedure pursuant to section G.1.c.(1)(a) of this Chapter, a reduction in the CMAC in a locality below the level in effect at the end of the previous calendar year that would otherwise occur pursuant to sections G.1.c., and G.1.d., of this Chapter may be waived pursuant to this section G.1.c.(3).

(a) Waiver based on balance billing rates. Except as provided in section G.1.d.(3)(b) of this Chapter such a reduction will be waived if there has been excessive balance billing in the locality for the procedure

involved. For this purpose, the extent of balance billing will be determined based on a review of all services under the procedure code involved in the prior year (or most recent period for which data are available). If the number of services for which balance billing was not required was less than 60 percent of all services provided, the Director will determine that there was an excessive balance billing with respect to that procedure in that locality and will waive the reduction in the CMAC that would otherwise occur. A decision by the Director to waive or not to waive the reduction is not subject to the appeal and hearing procedures of Chapter 10 of this regulation.

(b) Exception. As an exception to section G.1.d.(3)(a) of this Chapter, the waiver required by that section shall not be applicable in the case of any procedure code for which there were not CHAMPUS claims in the locality accounting for at least 50 services. A waiver may, however, be granted in such cases pursuant to section G.1.d.(3)(c) of this Chapter.

(c) Waiver based on other evidence that adequate access to care would be impaired. The Director, OCHAMPUS may waive a reduction that would otherwise occur (or restore a reduction that was already taken) if the Director determines that available evidence shows that the reduction would impair adequate access. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the number of such providers who are CHAMPUS Participating Providers, the number of CHAMPUS beneficiaries in the area, and other relevant factors. Providers or beneficiaries in a locality may submit to the Director, OCHAMPUS a petition, together with appropriate documentation regarding relevant factors, for a determination that adequate access would be impaired. The Director, OCHAMPUS will consider and respond to all such petitions. Petitions may be filed at any time. Any petition received by the date which is 120 days prior to the implementation of a recalculation of CMACs will be assured of consideration prior that implementation. The Director, OCHAMPUS may establish procedures for handling petitions. A decision by the Director to waive or not to waive a reduction is not subject to the appeal and hearing procedures of Chapter 10 of this regulation.

e. Special rules for 1991.

(1) Prevailing charge levels for care provided on or after January 1, 1991, and before the 1992 prevailing charge levels take effect shall be the same as those in effect on December 31, 1990, except that prevailing charge levels for care provided on or after October 7, 1991 shall be those established pursuant to this paragraph G.1.e. of this section.

(2) Appropriate charge levels will be established for each locality for which a prevailing charge level was in effect immediately prior to October 7, 1991. For each procedure, the appropriate charge level shall be the prevailing charge level in effect immediately prior to October 7, 1991, adjusted as provided in G.1.e.(2)(a) through (c) of this section.

(a) For each overpriced procedure, the level shall be reduced by fifteen percent. For this purpose, overpriced procedures are the procedures determined by the Physician Payment Review Commission to be overvalued pursuant to the process established under the Medicare program, other procedures

considered overvalued in the Medicare program (for which Congress directed reductions in Medicare allowable levels for 1991), radiology procedures and pathology procedures.

(b) For each other procedure, the level shall remain unchanged. For this purpose, other procedures are procedures which are not overpriced procedures or primary care procedures.

(c) For each primary care procedure, the level shall be adjusted by the MEI, as the MEI is applied to Medicare prevailing charge levels. For this purpose, primary care procedures include maternity care and delivery services and well baby care services.

f. Special transition rule for 1992.

(1) For purposes of calculating the national appropriate charge levels for 1992, the prior year's appropriate charge level for each service will be considered to be the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period of July 1, 1986 to June 30, 1987 (determined as under paragraph G.1.b.(2) of this section), adjusted to calendar year 1991 based on the adjustments made for maximum CHAMPUS prevailing charge levels through 1990 and the application of paragraph G.1.e. of this section for 1991.

(2) The adjustment to calendar year 1991 of the product of paragraph G.1.f.(1) of this section shall be as follows:

(a) For procedures other than those described in paragraph G.1.f.(2)(b) of this section, the adjustment to 1991 shall be on the same basis as that provided under paragraph G.1.e. of this section.

(b) For any procedure that was considered an overpriced procedure for purposes of the 1991 prevailing charge levels under paragraph G.1.e. of this section for which the resulting 1991 prevailing charge level was less than 150 percent of the Medicare converted relative value unit, the adjustment to 1991 for purposes of the special transition rule for 1992 shall be as if the procedure had been treated under paragraph G.1.e.(2)(b) of this section for purposes of the 1991 prevailing charge level.

g. Adjustments and procedural rules.

(1) The Director, OCHAMPUS may make adjustments to the appropriate charge levels calculated pursuant to paragraphs G.1.c. and G.1.e. of this section to correct any anomalies resulting from data or statistical factors, significant differences between Medicare-relevant information and CHAMPUS-relevant considerations or other special factors that fairness requires be specially recognized. However, no such adjustment may result in reducing an appropriate charge level.

(2) The Director, OCHAMPUS will issue procedural instructions for administration of the allowable charge method.

h. Clinical laboratory services. The allowable charge for clinical diagnostic laboratory test services shall be calculated in the same manner as allowable charges for other individual health care providers are calculated pursuant to paragraphs G.1.a. through G.1.d. of this Chapter, with the following exceptions and clarifications.

(1) The calculation of national prevailing charge levels, national appropriate charge levels and national CMACs for laboratory services shall begin in calendar year 1993. For purposes of the 1993 calculation, the prior year's national appropriate charge level or national prevailing charge level shall be the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the period July 1, 1991, through June 30, 1992 (referred to in this paragraph G.1.h. of this Chapter as the "base period").

(2) For purposes of comparison to Medicare allowable payment amounts pursuant to paragraph G.1.c. of this Chapter, the Medicare national laboratory payment limitation amounts shall be used.

(3) For purposes of establishing laboratory service local CMACs pursuant to paragraph G.1.d. of this Chapter, the adjustment factor shall equal the ratio of the local average charge (standardized for the distribution clinical laboratory services) to the national average charge for all clinical laboratory services during the base period.

(4) For purposes of a special locality-based phase-in provision similar to that established by paragraph G.1.d.(2) of this Chapter, the CMAC in a locality will not be less than 85 percent of the maximum charge level in effect for that locality during the base period.

i. The allowable charge for physician assistant services other than assistant-at-surgery may not exceed 85 percent of the allowable charge for a comparable service rendered by a physician performing the service in a similar location. For cases in which the physician assistant and the physician perform component services of a procedure other than assistant-at-surgery (e.g., home, office or hospital visit), the combined allowable charge for the procedure may not exceed the allowable charge for the procedure rendered by a physician alone. The allowable charge for physician assistant services performed as an assistant-at-surgery may not exceed 65 percent of the allowable charge for a physician serving as an assistant surgeon when authorized as CHAMPUS benefits in accordance with the provisions of Chapter 4 C.3.c. of this Part. Physician assistant services must be billed through the employing physician who must be an authorized CHAMPUS provider.

j. A charge that exceeds the CHAMPUS Maximum Allowable charge can be determined to be allowable only when unusual circumstances or medical complications justify the higher charge. The allowable charge may not exceed the billed charge under any circumstances.

2. All-inclusive rate. Claims from individual health-care professional providers for services rendered to CHAMPUS beneficiaries residing in an RTC that is either being reimbursed on an all-inclusive per diem rate, or is billing an all-inclusive per diem rate, shall be denied; with the exception of

independent health-care professionals providing geographically distant family therapy to a family member residing a minimum of 250 miles from the RTC or covered medical services related to a nonmental health condition rendered outside the RTC. Reimbursement for individual professional services is included in the rate paid the institutional provider.

3. Alternative method. The Director, OCHAMPUS, or a designee, may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to ensure a high level of acceptance of the CHAMPUS-determined charge by the individual health-care professionals or other noninstitutional health-care providers furnishing services and supplies to CHAMPUS beneficiaries. Alternative methods may not result in reimbursement greater than the allowable charge method above.

H. REIMBURSEMENT UNDER THE MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM

The Military-Civilian Health Services Partnership Program, as authorized by Section 1096, Chapter 55, Title 10, provides for the sharing of staff, equipment, and resources between the civilian and military health care system

in order to achieve more effective, efficient, or economical health care for authorized beneficiaries. Military treatment facility commanders, based upon the authority provided by their respective Surgeons General of the military departments, are responsible for entering into individual partnership agreements only when they have determined specifically that use of the Partnership Program is more economical overall to the Government than referring the need for health care services to the civilian community under the normal operation of the CHAMPUS Program. (See Section P. of Chapter 1, for general requirements of the Partnership Program.)

1. Reimbursement of institutional health care providers. Reimbursement of institutional health care providers under the Partnership Program shall be on the same basis as non-Partnership providers.

2. Reimbursement of individual health-care professionals and other non-institutional health care providers. Reimbursement of individual health care professional and other non-institutional health care providers shall be on the same basis as non-Partnership providers as detailed in Section G. of this chapter.

I. ACCOMMODATION OF DISCOUNTS UNDER PROVIDER REIMBURSEMENT METHODS

1. General rule. The Director, OCHAMPUS (or designee) has authority to reimburse a provider at an amount below the amount usually paid pursuant to this chapter when, under a program approved by the Director, the provider has agreed to the lower amount.

2. Special applications. The following are examples of applications of the general rule; they are not all inclusive.

a. In the case of individual health care professionals and other noninstitutional providers, if the discounted fee is below the provider's normal billed charge and the prevailing charge level (see section G. of this chapter), the discounted fee shall be the provider's actual billed charge and the CHAMPUS allowable charge.

b. In the case of institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under subsection A.1. of this chapter or per-diem amount under subsection A.2. of this chapter), if the discount rate is lower than the pre-set rate, the discounted rate shall be the CHAMPUS-determined allowable cost. This is an exception to the usual rule that the pre-set rate is paid regardless of the institutional provider's billed charges or other factors.

3. Procedures.

a. This section only applies when both the provider and the Director have agreed to the discounted payment rate. The Director's agreement may be in the context of approval of a program that allows for such discounts.

b. The Director of OCHAMPUS may establish uniform terms, conditions and limitations for this payment method in order to avoid administrative complexity.

J. OUTSIDE THE UNITED STATES

The Director, OCHAMPUS, or a designee, shall determine the appropriate reimbursement method or methods to be used in the extension of CHAMPUS benefits for otherwise covered medical services or supplies provided by hospitals or other institutional providers, physicians or other individual professional providers, or other providers outside the United States.

K. IMPLEMENTING INSTRUCTIONS

The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this chapter.

CHAPTER 15

QUALITY AND UTILIZATION PEER REVIEW ORGANIZATION PROGRAM

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CHAPTER 15
QUALITY AND UTILIZATION REVIEW PEER REVIEW ORGANIZATION PROGRAM

A. GENERAL

1. Purpose. The purpose of this chapter is to establish rules and procedures for the CHAMPUS Quality and Utilization Review Peer Review Organization program.

2. Applicability of program. All claims submitted for health services under CHAMPUS are subject to review for quality of care and appropriate utilization. The Director, OCHAMPUS shall establish generally accepted standards, norms and criteria as are necessary for this program of utilization and quality review. These standards, norms and criteria shall include, but not be limited to, need for inpatient admission or inpatient or outpatient service, length of inpatient stay, intensity of care, appropriateness of treatment, and level of institutional care required. The Director, OCHAMPUS may issue implementing instructions, procedures and guidelines for retrospective, concurrent and prospective review.

3. Contractor implementation. The CHAMPUS Quality and Utilization Review Peer Review Organization program may be implemented through contracts administered by the Director, OCHAMPUS. These contractors may include contractors that have exclusive functions in the area of utilization and quality review, fiscal intermediary contractors (which perform these functions along with a broad range of administrative services), and managed care contractors (which perform a range of functions concerning management of the delivery and financing of health care services under CHAMPUS). Regardless of the contractors involved, utilization and quality review activities follow the same standards, rules and procedures set forth in this chapter, unless otherwise specifically provided in this chapter or elsewhere in this Regulation.

4. Medical issues affected. The CHAMPUS Quality and Utilization Review Peer Review Organization program is distinguishable in purpose and impact from other activities relating to the administration and management of CHAMPUS in that the Peer Review Organization program is concerned primarily with medical judgments regarding the quality and appropriateness of health care services. Issues regarding such matters as benefit limitations are similar, but, if not determined on the basis of medical judgments, are governed by CHAMPUS rules and procedures other than those provided in this chapter. (See, for example, Chapter 7 regarding claims submission, review and payment.) Based on this

purpose, a major attribute of the Peer Review Organization program is that medical judgements are made by (directly or pursuant to guidelines and subject to direct review) reviewers who are peers of the health care providers providing the services under review.

5. Provider responsibilities. Because of the dominance of medical judgements in the quality and utilization review program, principal responsibility for complying with program rules and procedures rests with health care providers. For this reason, there are limitations, set forth in this chapter and in paragraph H, Chapter 4, on the extent to which beneficiaries may be held financially liable for health care services not provided in conformity with rules and procedures of the quality and utilization review program concerning medical necessity of care.

6. Medicare rules used as model. The CHAMPUS Quality and Utilization Review Peer Review Organization program, based on specific statutory authority, follows many of the quality and utilization review requirements and procedures in effect for the Medicare Peer Review Organization program, subject to adaptations appropriate for the CHAMPUS program.

B. OBJECTIVES AND GENERAL REQUIREMENTS OF REVIEW SYSTEM.

1. In general. Broadly, the program of quality and utilization review has as its objective to review the quality, completeness and adequacy of care provided, as well as its necessity, appropriateness and reasonableness.

2. Payment exclusion for services provided contrary to utilization and quality standards.

a. In any case in which health care services are provided in a manner determined to be contrary to quality or necessity standards established under the quality and utilization review program, payment may be wholly or partially excluded.

b. In any case in which payment is excluded pursuant to paragraph B.2.a. of this chapter, the patient (or the patient's family) may not be billed for the excluded services.

c. Limited exceptions and other special provisions pertaining to the requirements established in paragraphs B.2.a. and b. of this chapter, are set forth in Chapter 4, paragraph H.

3. Review of services covered by DRG-based payment system. Application of these objectives in the context of hospital services covered by the DRG-based payment system also includes a validation of diagnosis and procedural information that determines CHAMPUS reimbursement, and a review of the necessity and appropriateness of care for which payment is sought on an outlier basis.

4. Preauthorization and other utilization review procedures.

a. In general. All health care services for which payment is sought under CHAMPUS are subject to review for appropriateness of utilization. The

procedures for this review may be prospective (before the care is provided), concurrent (while the care is in process), or retrospective (after the care has been provided). Regardless of the procedures of this utilization review, the same generally accepted standards, norms and criteria for evaluating the necessity, appropriateness and reasonableness of the care involved shall apply. The Director, OCHAMPUS shall establish procedures for conducting reviews, including identification of types of health care services for which preauthorization or concurrent review shall be required. Preauthorization or concurrent review may be required for any categories of health care services. Except where required by law, the categories of health care services for which preauthorization or concurrent review is required may vary in different geographical locations or for different types of providers.

b. Preauthorization procedures. With respect to categories of health care (inpatient or outpatient) for which preauthorization is required, the following procedures shall apply:

(1) The requirement for preauthorization shall be widely publicized to beneficiaries and providers.

(2) All requests for preauthorization shall be responded to in writing. Notification of approval or denial shall be sent to the beneficiary. Approvals shall specify the health care services and supplies approved and identify any special limits or further requirements applicable to the particular case.

(3) An approved preauthorization shall state the number of days, appropriate for the type of care involved, for which it is valid. In general, preauthorizations will be valid for 30 days. If the services or supplies are not obtained within the number of days specified, a new preauthorization request is required.

c. Payment reduction for noncompliance with required utilization review procedures.

(1) Paragraph B.4.c. of this chapter applies to any case in which:

(a) A provider was required to obtain preauthorization or continued stay (in connection with required concurrent review procedures) approval.

(b) The provider failed to obtain the necessary approval;
and

(c) The health care services have not been disallowed on the basis of necessity, appropriateness or reasonableness.

In such a case, reimbursement will be reduced, unless such reduction is waived based on special circumstances.

(2) In a case described in paragraph B.4.c.(1) of this chapter, reimbursement will be reduced, unless such reduction is waived based on special circumstances. The amount of this reduction shall be ten percent of the amount otherwise allowable for services for which preauthorization (including preauthorization for continued stays in connection with concurrent review requirements) approval should have been obtained, but was not obtained. In the case of hospital admissions reimbursed under the DRG-based payment system, the reduction shall be taken against the percentage (between zero and 100 percent) of the total reimbursement equal to the number of days of care provided without preauthorization approval, divided by the total length of stay for the admission. In the case of institutional payments based on per diem payments, the reduction shall be taken only against the days of care provided without preauthorization approval. For care for which payment is on a per service basis, the reduction shall be taken only against the amount that relates to the services provided without preauthorization approval. Unless otherwise specifically provided under procedures issued by the Director, OCHAMPUS, the effective date of any preauthorization approval shall be the date on which a properly submitted request was received by the review organization designated for that purpose.

(3) The payment reduction set forth in paragraph B.4.c.(2) of this chapter may be waived by the Director, OCHAMPUS when the provider could not reasonably have been expected to know of the preauthorization requirement or some other special circumstance justifies the waiver.

(4) Services for which payment is disallowed under paragraph B.4.c. of this chapter may not be billed to the patient (or the patient's family).

C. HOSPITAL COOPERATION

All hospitals which participate in CHAMPUS and submit CHAMPUS claims are required to provide all information necessary for CHAMPUS to properly process the claims. In order for CHAMPUS to be assured that services for which claims are submitted meet quality of care standards, hospitals are required to provide the Peer Review Organization (PRO) responsible for quality review with all the information, within timeframes to be established by OCHAMPUS, necessary to perform the review functions required by this chapter. Additionally, all participating hospitals shall provide CHAMPUS beneficiaries, upon admission, with information about the admission and quality review system including their appeal rights. A hospital which does not cooperate in this activity shall be subject to termination as a CHAMPUS-authorized provider.

1. Documentation that the beneficiary has received the required information about the CHAMPUS PRO program must be maintained in the same manner as is the notice required for the Medicare program by 42 CFR 466.78(b).

2. The physician attestation and physician acknowledgement required for Medicare under 42 CFR 412.40 and 412.46 are also required for CHAMPUS as a condition for payment and may be satisfied by the same statements as required for Medicare, with substitution or addition of "CHAMPUS" when the word "Medicare" is used.

3. Participating hospitals must execute a memorandum of understanding with the PRO providing appropriate procedures for implementation of the PRO program.

4. Participating hospitals may not charge a CHAMPUS beneficiary for inpatient hospital services excluded on the basis of Chapter 4, section G.1. (not medically necessary), section G.3. (inappropriate level), or section G.7. (custodial care) unless all of the conditions established by 42 CFR 412.42(c) with respect to Medicare beneficiaries have been met with respect to the CHAMPUS beneficiary. In such cases in which the patient requests a PRO review while the patient is still an inpatient in the hospital, the hospital shall provide to the PRO the records required for the review by the close of business of the day the patient requests review, if such request was made before noon. If the hospital fails to provide the records by the close of business, that day and any subsequent working day during which the hospital continues to fail to provide the records shall not be counted for purposes of the two-day period of 42 CFR 412.42(c)(3)(ii).

5. With respect to cases subject to preadmission review, the provisions of 42 C.F.R. 466.78(b)(5)-(b)(7) shall apply to CHAMPUS cases as those provisions apply to Medicare cases.

D. AREAS OF REVIEW

1. Admissions. The following areas shall be subject to review to determine whether inpatient care was medically appropriate and necessary, was delivered in the most appropriate setting and met acceptable standards of quality. This review may include preadmission or prepayment review when appropriate.

a. Transfers of CHAMPUS beneficiaries from a hospital or hospital unit subject to the CHAMPUS DRG-based payment system to another hospital or hospital unit.

b. CHAMPUS admissions to a hospital or hospital unit subject to the CHAMPUS DRG-based payment system which occur within a certain period (specified by OCHAMPUS) of discharge from a hospital or hospital unit subject to the CHAMPUS DRG-based payment system.

c. A random sample of other CHAMPUS admissions for each hospital subject to the CHAMPUS DRG-based payment system.

d. CHAMPUS admissions in any DRGs which have been specifically identified by OCHAMPUS for review or which are under review for any other reason.

2. DRG validation. The review organization responsible for quality of care reviews shall be responsible for ensuring that the diagnostic and procedural information reported by hospitals on CHAMPUS claims which is used by the fiscal intermediary to assign claims to DRGs is correct and matches the information contained in the medical records. In order to accomplish this, the following review activities shall be done.

- a. Perform DRG validation reviews of each case under review.
 - b. Review of claim adjustments submitted by hospitals which result in the assignment of a higher weighted DRG.
 - c. Review for physician certification as to the major diagnoses and procedures and the physician's acknowledgment of annual receipt of the penalty statement as contained in the Medicare regulations at 42 CFR 412.40 and 412.46.
 - d. Review of a sample of claims for each hospital reimbursed under the CHAMPUS DRG-based payment system. Sample size shall be determined based upon the volume of claims submitted.
3. Outlier review. Claims which qualify for additional payment as a long-stay outlier or as a cost-outlier shall be subject to review to ensure that the additional days or costs were medically necessary and appropriate and met all other requirements for CHAMPUS coverage. In addition, claims which qualify as short-stay outliers shall be reviewed to ensure that the admission was medically necessary and appropriate and that the discharge was not premature.
4. Procedure review. Claims for procedures identified by OCHAMPUS as subject to a pattern of abuse shall be the subject of intensified quality assurance review.
5. Other review. Any other cases or types of cases identified by OCHAMPUS shall be subject to focused review.

E. ACTIONS AS A RESULT OF REVIEW

1. Findings related to individual claims. If it is determined, based upon information obtained during reviews, that a hospital has misrepresented admission, discharge, or billing information, or is found to have quality of care defects, or has taken an action that results in the unnecessary admissions of an individual entitled to benefits, unnecessary multiple admission of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, the PRO, in conjunction with the fiscal intermediary, shall, as appropriate:
- a. Deny payment for or recoup (in whole or in part) any amount claimed or paid for the inpatient hospital and professional services related to such determination.
 - b. Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.
 - c. Advise the provider and beneficiary of appeal rights, as required by Chapter 10 of this Regulation.
 - d. Notify OCHAMPUS of all such actions.

2. Findings related to a pattern of inappropriate practices. In all cases where a pattern of inappropriate admissions and billing practices that have the effect of circumventing the CHAMPUS DRG-based payment system is identified, OCHAMPUS shall be notified of the hospital and practice involved.

3. Revision of coding relating to DRG validation. The following provisions apply in connection with the DRG validation process set forth in subsection D.2. of this chapter.

a. If the diagnostic and procedural information attested to by the attending physician is found to be inconsistent with the hospital's coding or DRG assignment, the hospital's coding on the CHAMPUS claim will be appropriately changed and payments recalculated on the basis of the appropriate DRG assignment.

b. If the information attested to by the physician as stipulated under subsection E.2. of this chapter is found not to be correct, the PRO will change the coding and assign the appropriate DRG on the basis of the changed coding.

F. SPECIAL PROCEDURES IN CONNECTION WITH CERTAIN TYPES OF HEALTH CARE SERVICES OR CERTAIN TYPES OF REVIEW ACTIVITIES.

1. In general. Many provisions of this chapter are directed to the context of services covered by the CHAMPUS DRG-based payment system. This section, however, is also applicable to other services. In addition, many provisions of this chapter relate to the context of peer review activities performed by Peer Review Organizations whose sole functions for CHAMPUS relate to the Quality and Utilization Review Peer Review Organization program. However, it also applies to review activities conducted by contractors who have responsibilities broader than those related to the quality and utilization review program. Paragraph F of this chapter authorizes certain special procedures that will apply in connection with such services and such review activities.

2. Services not covered by the DRG-based payment system. In implementing the quality and utilization review program in the context of services not covered by the DRG-based payment system, the Director, OCHAMPUS may establish procedures, appropriate to the types of services being reviewed, substantively comparable to services covered by the DRG-based payment system regarding obligations of providers to cooperate in the quality and utilization review program, authority to require appropriate corrective actions and other procedures. The Director, OCHAMPUS may also establish such special, substantively comparable procedures in connection with review of health care services which, although covered by the DRG-based payment method, are also affected by some other special circumstances concerning payment method, nature of care, or other potential utilization or quality issue.

3. Peer review activities by contractors also performing other administration or management functions.

a. Sole-function PRO versus multi-function PRO. In all cases, peer review activities under the Quality and Utilization Review Peer Review

Organization program are carried out by physicians and other qualified health care professionals, usually under contract with OCHAMPUS. In some cases, the Peer Review Organization contractor's only functions are pursuant to the quality and utilization review program. In paragraph F.3, of this chapter, this type of contractor is referred to as a "sole function PRO." In other cases, the Peer Review Organization contractor is also performing other functions in connection with the administration and management of CHAMPUS. In paragraph F.3, of this chapter, this type of contractor is referred to as a "multi-function PRO." As an example of the latter type, managed care contractors may perform a wide range of functions regarding management of the delivery and financing of health care services under CHAMPUS, including but not limited to functions under the Quality and Utilization Review Peer Review Organization program.

b. Special rules and procedures. With respect to multi-function PROs, the Director, OCHAMPUS may establish special procedures to assure the independence of the Quality and Utilization Review Peer Review Organization program and otherwise advance the objectives of the program. These special rules and procedures include, but are not limited to, the following:

(1) A reconsidered determination that would be final in cases involving sole-function PROs under paragraph I.2. of this chapter will not be final in connection with multi-function PROs. Rather, in such cases (other than any case which is appealable under paragraph I.3. of this chapter), an opportunity for a second reconsideration shall be provided. The second reconsideration will be provided by OCHAMPUS or another contractor independent of the multi-function PRO that performed the review. The second reconsideration may not be further appealed by the provider.

(2) Procedures established by paragraphs G through M of this chapter shall not apply to any action of a multi-function PRO (or employee or other person or entity affiliated with the PRO) carried out in performance of functions other than functions under this section.

G. PROCEDURES REGARDING INITIAL DETERMINATIONS

The CHAMPUS PROs shall establish and follow procedures for initial determinations that are substantively the same or comparable to the procedures applicable to Medicare under 42 CFR 466.83 to 466.104. In addition, these procedures shall provide that a PRO's determination that an admission is medically necessary is not a guarantee of payment by CHAMPUS; normal CHAMPUS benefit and procedural coverage requirements must also be applied.

H. PROCEDURES REGARDING RECONSIDERATIONS

The CHAMPUS PROs shall establish and follow procedures for reconsiderations that are substantively the same or comparable to the procedures applicable to

reconsiderations under Medicare pursuant to 42 CFR 473.15 to 473.34, except that the time limit for requesting reconsideration (see 42 CFR 473.20(a)(1)) shall be 90 days. A PRO reconsidered determination is final and binding upon all parties to the reconsideration except to the extent of any further appeal pursuant to section I. of this chapter.

I. APPEALS AND HEARINGS

1. Beneficiaries may appeal a PRO reconsideration determination to OCHAMPUS and obtain a hearing on such appeal to the extent allowed and under the procedures set forth in Chapter 10, section D.

2. Except as provided in subsection I.3., a PRO reconsidered determination may not be further appealed by a provider.

3. A provider may appeal a PRO reconsideration determination to OCHAMPUS and obtain a hearing on such appeal to the extent allowed under the procedures set forth in Chapter 10, section D. if it is a determination pursuant to Chapter 4, section H. that the provider knew or could reasonably have been expected to know that the services were excludable.

4. For purposes of the hearing process, a PRO reconsidered determination shall be considered as the procedural equivalent of a formal review determination under Chapter 10, unless revised at the initiative of the Director, OCHAMPUS prior to a hearing on the appeal, in which case the revised determination shall be considered as the procedural equivalent of a formal review determination under Chapter 10.

5. The provisions of Chapter 10, section E. concerning final action shall apply to hearings cases.

J. ACQUISITION, PROTECTION AND DISCLOSURE OF PEER REVIEW INFORMATION

The provisions of 42 CFR Part 476, except section 476.108, shall be applicable to the CHAMPUS PRO program as they are to the Medicare PRO program.

K. LIMITED IMMUNITY FROM LIABILITY FOR PARTICIPANTS IN PRO PROGRAM

The provisions of section 1157 of the Social Security Act (42 U.S.C. 1320c-6) are applicable to the CHAMPUS PRO program in the same manner as they apply to the Medicare PRO program. Section 1102(g) of title 10, United States Code also applies to the CHAMPUS PRO program.

L. ADDITIONAL PROVISION REGARDING CONFIDENTIALITY OF RECORDS

1. General rule. The provisions of 10 U.S.C. 1102 regarding the confidentiality of medical quality assurance records shall apply to the activities of the CHAMPUS PRO program as they do to the activities of the external civilian PRO program that reviews medical care provided in military hospitals.

2. Specific applications.

a. Records concerning PRO deliberations are generally nondisclosable quality assurance records under 10 U.S.C. 1102.

b. Initial denial determinations by PROs pursuant to section G. of this chapter (concerning medical necessity determinations, DRG validation actions, etc.) and subsequent decisions regarding those determinations are not nondisclosable quality assurance records under 10 U.S.C. 1102.

c. Information the subject of mandatory PRO disclosure under 42 CFR Part 476 is not a nondisclosable quality assurance record under 10 U.S.C. 1102.

M. OBLIGATIONS, SANCTIONS AND PROCEDURES

1. The provisions of 42 CFR 1004.1 - 1004.80 shall apply to the CHAMPUS PRO program as they do the Medicare PRO program, except that the functions specified in those sections for the Office of Inspector General of the Department of Health and Human Services shall be the responsibility of OCHAMPUS.

2. The provisions of 42 U.S.C. section 1395ww(f)(2) concerning circumvention by any hospital of the applicable payment methods for inpatient services shall apply to CHAMPUS payment methods as they do to Medicare payment methods.

3. The Director, or a designee, of CHAMPUS shall determine whether to impose a sanction pursuant to subsections M.1. and M.2. of this chapter. Providers may appeal adverse sanctions decisions under the procedures set forth in Chapter 10, section D.

CHAPTER 16

SUPPLEMENTAL HEALTH CARE PROGRAM FOR ACTIVE DUTY MEMBERS

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CHAPTER 16
SUPPLEMENTAL HEALTH CARE PROGRAM FOR ACTIVE DUTY MEMBERS

A. Purpose and applicability.

1. The purpose of this chapter is to implement, with respect to health care services provided under the supplemental health care program for active duty members of the uniformed services, the provision of 10 U.S.C. 1074(c). This section of law authorizes DoD to establish for the supplemental care program the same payment rules, subject to appropriate modifications, as apply under CHAMPUS.

2. This chapter applies to the program, known as the supplemental care program, which provides for the payment by the uniformed services to private sector health care providers for health care services provided to active duty members of the uniformed services. Although not part of CHAMPUS, the supplemental care program is similar to CHAMPUS in that it is a program for the uniformed services to purchase civilian health care services for active duty members. For this reason, the Director, OCHAMPUS, assists the uniformed services in the administration of the supplemental care program.

3. This chapter applies to all health care services covered by CHAMPUS. For purposes of this chapter, health care services ordered by a military treatment facility (MTF) provider for an MTF patient (who is not an active duty member) for whom the MTF provider maintains responsibility are also covered by the supplemental care program and subject to the requirements of this chapter.

B. Obligation of providers concerning payment for supplemental health care for active duty members.

1. Hospitals covered by DRG-based payment system. For a hospital covered by the CHAMPUS DRG-based payment system to maintain its status as an authorized provider for CHAMPUS pursuant to Chapter 6, that hospital must also be a participating provider for purposes of the supplemental care program. As a participating provider, each hospital must accept the DRG-based payment system amount determined pursuant to Chapter 14 as payment in full for the hospital services covered by the system. The failure of any hospital to comply with this obligation subjects that hospital to exclusion as a CHAMPUS-authorized provider.

2. Other participating providers. For any institutional or individual provider, other than those described in paragraph B.1 of this Chapter that is a participating provider, the provider must also be a participating provider for purposes of the supplemental care program. The provider must accept the CHAMPUS allowable amount determined pursuant to Chapter 14 as payment in full for the hospital services covered by the system. The failure of any provider to comply with this obligation subjects the provider to exclusion as a participating provider.

C. General rule for payment and administration. Subject to the special rules and procedures in paragraph D. of this chapter, and the waiver authority in paragraph E. of this chapter, as a general rule the provisions of Chapter 14 shall govern payment and administration of claims under the supplemental care program as they do claims under CHAMPUS. To the extent necessary to interpret or implement the provisions of Chapter 14, related provisions of DoD 6010.8-R shall also be applicable.

D. Special rules and procedures. As exceptions to the general rule in paragraph C. of this chapter, the special rules and procedures in this chapter shall govern payment and administration of claims under the supplemental care program. These special rules and procedures are subject to the waiver authority of paragraph E. of this chapter.

1. There is no patient cost sharing under the supplemental care program. All amounts due to be paid to the provider shall be paid by the program.

2. Preauthorization by the uniformed services of each service, except for services in cases of medical emergency (for which the definition in Chapter 2 shall apply), is required for the supplemental care program. It is the responsibility of the active duty members to obtain preauthorization for each service. With respect to each emergency inpatient admission, after such time as the emergency condition is addressed, authorization for any proposed continued stay must be obtained within two working days of admission.

3. With respect to the filing of claims and similar administrative matters for which DoD 6010.8-R refers to activities of the CHAMPUS fiscal intermediaries, for purposes of the supplemental care program, responsibilities for claims processing, payment and some other administrative matters may be assigned by the Director, OCHAMPUS to the same fiscal intermediaries, other contractor, or to the nearest military medical treatment facility or medical claims office.

4. The annual cost pass-throughs for capital and direct medical education costs that are available under the CHAMPUS DRG-based payment system are also available, upon request, under the supplemental care program. To obtain payment include the number of active duty bed days as a separate line item on the annual request to the CHAMPUS fiscal intermediaries.

5. For providers other than participating providers, the Director, OCHAMPUS may authorize payment in excess of CHAMPUS allowable amounts. No provider may bill an active duty member any amount in excess of the CHAMPUS allowable amount.

E. Waiver authority. With the exception of statutory requirements, any restrictions or limitations pursuant to the general rule in paragraph C of this chapter, and special rules and procedures in paragraph D of this chapter may be waived by the Director, OCHAMPUS at the request of an authorized official of the uniformed service concerned, based on a determination that such waiver is necessary to assure adequate availability of health care services to active duty members.

F. Authorities.

1. The Uniformed Services may establish additional procedures, consistent with this chapter, for the effective administration of the supplemental care program in their respective services.

2. The Assistant Secretary of Defense for Health Affairs is responsible for the overall policy direction of the supplemental care program and the administration of this chapter.

3. The Director, OCHAMPUS shall issue procedural requirements for the implementation of this Chapter, including the requirement for claims submission similar to those established by Chapter 17.

SUPPLEMENTARY

INFORMATION

ERRATA

DEPARTMENT OF DEFENSE
PUBLICATION SYSTEM
CHANGE TRANSMITTAL

OFFICE OF THE SECRETARY OF DEFENSE
Assistant Secretary of Defense (Health Affairs)

CHANGE NO. 6
to July 1991, Reprint
DoD 6010.8-R
June 24, 1994

CIVILIAN HEALTH AND MEDICAL PROGRAM
OF THE UNIFORMED SERVICES (CHAMPUS)

The Acting Assistant Secretary of Defense (Health Affairs) has authorized the page changes to DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," July 1991 (Reprint).

PAGE CHANGES

Remove: 2-i through 2-iv, 2-3&2-4, 2-9&2-10, 2-17&2-18, 2-20a through 2-26, 4-i through 4-viii, 4-1 through 4-6b, 4-9b&4-10, 4-13d&4-14, 4-17&4-18, 4-21 through 4-24, 4-44 through 4-47, 4-50&4-51, 5-i&5-ii, 5-1&5-2, 6-i&6-ii, 6-3&6-4, 6-23 through 6-24, 6-27 through 6-31, 7-i&7-ii, 7-11 through 7-14, 14-i through 14-2, 14-18&14-18a, 14-21 through 14-26, 15-i through 15-6, and 16-i through 16-2

Insert: Attached replacement pages and new pages 2-v, 4-ix, 4-4a&4-4b, 4-51a&4-51b, 6-3a, 6-3b, 6-32, 6-33, 14-18b&14-18c, 14-27&14-28, 15-ii, 15-7 through 15-10, and 16-3

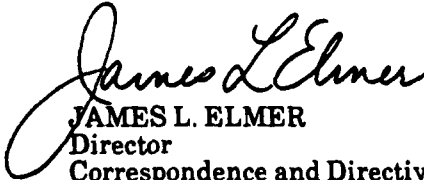
Changes appear on pages 2-i through 2-v, 2-4, 2-10, 2-17&2-18, 2-21, 2-22, 2-24, 2-25, 4-i, 4-iv, 4-vii, 4-2 through 4-4a, 4-5 through 4-6a, 4-9b, 4-14, 4-18, 4-22, 4-23, 4-45 through 4-46b, 4-50, 5-i, 5-2, 6-i&6-ii, 6-3 through 6-4, 6-23 through 6-24, 6-28 through 6-33, 7-ii, 7-11 through 7-13, 14-i, 14-1, 14-18, 14-18a, 14-21 through 14-24, 14-26, 15-i, 15-1 through 15-4, 15-7 through 15-9, and 16-i through 16-3 and are indicated by marginal bars.

EFFECTIVE DATE

The above changes are effective for services or supplies delivered on or after (1) November 5, 1990 for Coverage of Screening Mammography and Papanicolaou (PAP) Tests; (2) November 1, 1993 for Reimbursement of Providers, Claims Filing, and Participating Provider Program; (3) December 6, 1993 for Specialized Treatment Services, Nonavailability Statements, Peer Review Organization Program, and

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, THIS TRANSMITTAL SHOULD BE FILED WITH THE BASIC DOCUMENT

ERRATA - AD-A268034

NUMBER 6010.8-R, Change 6	DATE June 24, 1994	DEPARTMENT OF DEFENSE PUBLICATIONS SYSTEMS TRANSMITTAL
<p data-bbox="558 321 943 342">INSTRUCTIONS FOR RECIPIENTS (continued)</p> <p data-bbox="145 352 1323 468">Supplemental Care; (4) March 24, 1994 for Requirements for Coverage and Reimbursement of Services of Physicians in Teaching Settings; (5) October 1, 1994 for Delay of Grace Period for Partial Hospitalization Program; and (6) May 22, 1995 for Certified Marriage and Family Therapists.</p> <div data-bbox="665 468 1120 657"><p data-bbox="731 569 1120 657">JAMES L. ELMER Director Correspondence and Directives</p></div> <p data-bbox="145 783 315 846">Attachments 116 pages</p>		

CHAPTER 2

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Admission. The formal acceptance by a CHAMPUS authorized institutional provider of a CHAMPUS beneficiary for the purpose of diagnosis and treatment of illness, injury, pregnancy, or mental disorder.

Adopted Child. A child taken into one's own family by legal process and treated as one's own child. In case of adoption, CHAMPUS eligibility begins as of 12:01 a.m. of the day of the final adoption decree. NOTE: There is no CHAMPUS benefit entitlement during any interim waiting period.

All-Inclusive Per Diem Rate. The OCHAMPUS determined rate that encompasses the daily charge for inpatient care and, unless specifically excepted, all other treatment determined necessary and rendered as part of the treatment plan established for a patient, and accepted by OCHAMPUS.

Allowable Charge. The CHAMPUS-determined level of payment to physicians, other individual professional providers and other providers, based on one of the approved reimbursement methods set forth in Chapter 14 of this Regulation. Allowable charge also may be referred to as the CHAMPUS-determined reasonable charge.

Allowable Cost. The CHAMPUS-determined level of payment to hospitals or other institutions, based on one of the approved reimbursement methods set forth in Chapter 14 of this Regulation. Allowable cost may also be referred to as the CHAMPUS-determined reasonable cost.

Ambulance. A specially designed vehicle for transporting the sick or injured that contains a stretcher, linens, first aid supplies, oxygen equipment, and such lifesaving equipment required by state and local law, and that is staffed by personnel trained to provide first aid treatment.

Amount in Dispute. The amount of money, determined under this Regulation, that CHAMPUS would pay for medical services and supplies involved in an adverse determination being appealed if the appeal were resolved in favor of the appealing party. See Chapter 10 for additional information concerning the determination of "amount in dispute" under this Regulation.

Anesthesia Services. The administration of an anesthetic agent by injection or inhalation, the purpose and effect of which is to produce surgical anesthesia characterized by muscular relaxation, loss of sensation, or loss of consciousness when administered by or under the direction of a physician or dentist in connection with otherwise covered surgery or obstetrical care, or shock therapy. Anesthesia services do not include hypnosis or acupuncture.

Appealable Issue. Disputed questions of fact which, if resolved in favor of the appealing party, would result in the authorization of CHAMPUS benefits, or approval as an authorized provider in accordance with this Regulation. An appealable issue does not exist if no facts are in dispute, if no CHAMPUS benefits would be payable, or if there is no authorized provider, regardless of the resolution of any disputed facts. See Chapter 10 for additional information concerning the determination of "appealable issue" under this Regulation.

Appealing Party. Any party to the initial determination who files an appeal of an adverse determination or requests a hearing under the provisions of this Regulation.

Appropriate Medical Care

1. Services performed in connection with the diagnosis or treatment of disease

or injury, pregnancy, mental disorder, or well-baby care which are in keeping with the generally accepted norms for medical practice in the United States;

2. The authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training and education and is licensed or certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards; and

3. The services are furnished economically. For purposes of this Regulation, "economically" means that the services are furnished in the least expensive level of care or medical environment adequate to provide the required medical care regardless of whether or not that level of care is covered by CHAMPUS.

Approved Teaching Programs. For purposes of CHAMPUS, an approved teaching program is a program of graduate medical education which has been duly approved in its respective speciality or subspecialty by the Accreditation Council for Graduate Medical Education of the American Medical Association, by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, by the Council on Dental Education of the American Dental Association, or by the Council on Podiatry Education of the American Podiatry Association.

Assistant Secretary of Defense (Health Affairs). An authority of the Assistant Secretary of Defense (Health Affairs) includes any person designated by the Assistant Secretary to exercise the authority involved.

Attending Physician. The physician who has the primary responsibility for the medical diagnosis and treatment of the patient. A consultant, or an assistant surgeon, for example would not be an attending physician. Under very extraordinary circumstances, because of the presence of complex, serious, and multiple, but unrelated, medical conditions, a patient may have more than one attending physician concurrently rendering medical treatment during a single period of time. An attending physician also may be a teaching physician.

Authorized Provider. A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized to provide benefits under CHAMPUS in Chapter 6 of this Regulation.

Backup Hospital. A hospital which is otherwise eligible as a CHAMPUS institutional provider and which is fully capable of providing emergency care to a patient who develops complications beyond the scope of services of a given category of CHAMPUS authorized freestanding institutional provider and which is accessible from the site of the CHAMPUS authorized freestanding institutional provider within an average transport time acceptable for the types of medical emergencies usually associated with the type of care provided by the freestanding facility.

Balance billing. A provider seeking any payment, other than any payment relating to applicable and cost-sharing amounts, from a beneficiary for CHAMPUS covered services for any amount in excess of the applicable CHAMPUS allowable cost or charge.

Basic Program. The primary medical benefits authorized under Chapter 55 of title 10, United States Code, and set forth in Chapter 4 of this Regulation.

Beneficiary. An individual who has been determined to be eligible for CHAMPUS benefits, as set forth in Chapter 3 of this Regulation.

specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment. A custodial care determination is not precluded by the fact that a patient is under the care of a supervising or attending physician and that services are being ordered and prescribed to support and generally maintain the patient's condition, or provide for the patient's comfort, or ensure the manageability of the patient. Further, a custodial care determination is not precluded because the ordered and prescribed services and supplies are being provided by an R.N., L.P.N., or L.V.N.

NOTE: The determination of custodial care in no way implies that the care being rendered is not required by the patient; it only means that it is the kind of care that is not covered under CHAMPUS. A program of physical and mental rehabilitation which is designed to reduce a disability is not custodial care as long as the objective of the program is a reduced level of care.

Days. Calendar days.

Deceased Service Member. A person who, at the time of his or her death, was an active duty member of a Uniformed Service under a call or order that did not specify a period of 30 days or less; or a retiree of a Uniformed Service.

Deductible. Payment by a beneficiary of the first \$50 of the CHAMPUS-determined allowable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year; or for a family, the aggregate payment by two or more beneficiaries who submit claims of the first \$100.

Deductible Certificate. A statement issued to the beneficiary (or sponsor) by a CHAMPUS fiscal intermediary certifying to deductible amounts satisfied by a CHAMPUS beneficiary for any applicable fiscal year.

Defense Enrollment Eligibility Reporting System (DEERS). The automated system that is composed of two phases:

1. Enrolling all active duty and retired service members, their dependents, and the dependents of deceased service members, and
2. Verifying their eligibility for health care benefits in the direct care facilities and through CHAMPUS.

Dental Care. Services relating to the teeth and their supporting structures.

Dentist. Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery (D.D.S.) who is licensed to practice dentistry by an appropriate authority.

Dependent. A person who bears any of the following relationships to an active duty member (under a call or order that does not specify a period of 30 days or less), retiree, or deceased active duty member or retiree, of a Uniformed Service, that is, lawful spouse, former spouse (in certain circumstances), unremarried widow or widower, or child; or a spouse and child of an active duty member of the armed forces of foreign North Atlantic Treaty Organization (NATO) nations (refer to section B. in Chapter 3 of this Regulation).

Deserter or Desertion Status. A service member is a deserter, or in a desertion status, when the Uniformed Service concerned has made an administrative determination to that effect, or the member's period of unauthorized absence has resulted in a court-martial conviction of desertion. Administrative declarations of desertion normally are made when a member has been an unauthorized absentee for over 30 days, but particular circumstances may result in an earlier declaration. Entitlement to CHAMPUS benefits ceases as of 12:01 a.m. on the day following the day the desertion status is declared. Benefits are not to be authorized for treatment received during a period of unauthorized absence that results in a court-martial conviction for desertion. Dependent eligibility for benefits is reestablished when a deserter is returned to military control and continues, even though the member may be in confinement, until any discharge is executed. When a deserter status is later found to have been determined erroneously, the status of deserter is considered never to have existed, and the member's dependents will have been eligible continuously for benefits under CHAMPUS.

Diagnosis-Related Groups (DRGs). Diagnosis-related groups (DRGs) are a method of dividing hospital patients into clinically coherent groups based on the consumption of resources. Patients are assigned to the groups based on their principal diagnosis (the reason for admission, determined after study), secondary diagnoses, procedures performed, and the patient's age, sex, and discharge status.

Diagnostic Admission. An admission to a hospital or other authorized institutional provider, or an extension of a stay in such a facility, primarily for the purpose of performing diagnostic tests, examinations, and procedures.

Director, OCHAMPUS. An authority of the Director, OCHAMPUS includes any person designated by the Director, OCHAMPUS to exercise the authority involved.

Doctor of Dental Medicine (D.M.D.). A person who has received a degree in dentistry, that is, that department of the healing arts which is concerned with the teeth, oral cavity, and associated structures.

required); prognosis; problem list; and all inclusive current or anticipated monthly charges related to the proposed management plan. If the management plan involves the transfer of a beneficiary from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the management plan documentation.

Marriage and Family Therapist, Certified. An extramedical individual provider who meets the requirements outlined in Chapter 6 of the Regulation.

Maternity Care. Care and treatment related to conception, delivery, and abortion, including prenatal and postnatal care (generally through the 6th post-delivery week), and also including treatment of the complications of pregnancy.

Medicaid. Those medical benefits authorized under Title XIX of the Social Security Act (reference (h)) provided to welfare recipients and the medically indigent through programs administered by the various states.

Medical. The generally used term which pertains to the diagnosis and treatment of illness, injury, pregnancy, and mental disorders by trained and licensed or certified health professionals. For purposes of CHAMPUS, the term "medical" should be understood to include "medical, psychological, surgical, and obstetrical," unless it is specifically stated that a more restrictive meaning is intended.

Medical Emergency. The sudden and unexpected onset of a medical condition or the acute exacerbation of a chronic condition that is threatening to life, limb, or sight, and requires immediate medical treatment or which manifests painful symptomatology requiring immediate palliative efforts to alleviate suffering. Medical emergencies include heart attacks, cardiovascular accidents, poisoning, convulsions, kidney stones, and such other acute medical conditions as may be determined to be medical emergencies by the Director, OCHAMPUS, or a designee. In the case of a pregnancy, a medical emergency must involve a sudden and unexpected medical complication that puts the mother, the baby, or both, at risk. Pain would not, however, qualify a maternity case as an emergency, nor would incipient birth after the 34th week of gestation, unless an otherwise qualifying medical condition is present. Examples of medical emergencies related to pregnancy or delivery are hemorrhage, ruptured membrane with prolapsed cord, placenta previa, abruptio placenta, presence of shock or unconsciousness, suspected heart attack or stroke, or trauma (such as injuries received in an automobile accident).

Medically or Psychologically Necessary. The frequency, extent, and types of medical services or supplies which represent appropriate medical care and that are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, and mental disorders or that are reasonable and adequate for well-baby care.

Medical Supplies and Dressings (Consumables). Necessary medical or surgical supplies (exclusive of durable medical equipment) that do not withstand prolonged, repeated use and that are needed for the proper medical management of a condition for which benefits are otherwise authorized under CHAMPUS, on either an inpatient or outpatient basis. Examples include disposable syringes for a diabetic, colostomy sets, irrigation sets, and ace bandages.

Medicare. Those medical benefits authorized under Title XVIII of the Social Security Act (reference (h)) provided to persons 65 or older, certain disabled persons, or persons with chronic renal disease, through a national program administered by the DHHS, Health Care Financing Administration, Medicare Bureau.

Mental Disorder. For purposes of the payment of CHAMPUS benefits, a mental disorder is a nervous or mental condition that involves a clinically significant behavioral or psychological syndrome or pattern that is associated with a painful symptom, such as distress, and that impairs a patient's ability to function in one or more major life activities. Additionally, the mental disorder must be one of those conditions listed in the DSM-III.

Mental Health Counselor. An extramedical individual provider who meets the requirements outlined in Chapter 6 of this Regulation.

Mental Health Therapeutic Absence. A therapeutically planned absence from the inpatient setting. The patient is not discharged from the facility and may be away for periods of several hours to several days. The purpose of the therapeutic absence is to give the patient an opportunity to test his or her ability to function outside the inpatient setting before the actual discharge.

Mental Retardation. Subnormal general intellectual functioning associated with impairment of either learning and social adjustment or maturation, or both. The diagnostic classification of moderate and severe mental retardation relates to intelligence quotient (IQ) as follows:

1. Moderate. Moderate mental retardation IQ 36-51.
2. Severe. Severe mental retardation IQ 35 and under.

Missing in Action (MIA). A battle casualty whose whereabouts and status are unknown, provided the absence appears to be involuntary and the service member is not known to be in a status of unauthorized absence. **NOTE:** Claims for eligible CHAMPUS beneficiaries whose sponsor is classified as MIA are processed as dependents of an active duty service member.

Morbid Obesity. The body weight is 100 pounds over ideal weight for height and bone structure, according to the most current Metropolitan Life Table, and such weight is in association with severe medical conditions known to have higher mortality rates in association with morbid obesity; or, the

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per day, 5 days per week, which may embrace day, evening, night and weekend treatment programs which employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. Partial hospitalization is a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic environment. Partial hospitalization is an appropriate setting for crisis stabilization, treatment of partially stabilized mental health disorders, and a transition from an inpatient program when medically necessary. Such programs must enter into a participation agreement with CHAMPUS, and be accredited and in substantial compliance with the standards of the Mental Health Manual of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (formerly known as the Consolidated Standards).

Participating Provider. A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished services or supplies to a CHAMPUS beneficiary and that submits a CHAMPUS claim form and accepts assignment of the CHAMPUS determined allowable cost or charge as the total payment(even though less than the actual charge), whether paid for fully by the CHAMPUS allowable amount or requiring cost-sharing by the beneficiary (or sponsor). See Chapter 6.A.8. for more information on the Participating Provider.

Party to a Hearing. An appealing party or parties and CHAMPUS.

Party to the Initial Determination. Includes CHAMPUS and also refers to a CHAMPUS beneficiary and a participating provider of services whose interests have been adjudicated by the initial determination. In addition, a provider who has been denied approval as an authorized CHAMPUS provider is a party to that initial determination, as is a provider who is disqualified or excluded as an authorized provider under CHAMPUS, unless the provider is excluded based on a determination of abuse or fraudulent practices or procedures under another federal or federally funded program. See Chapter 10 for additional information concerning parties not entitled to administrative review under the CHAMPUS appeals and hearing procedures.

Pastoral Counselor. An extramedical individual provider who meets the requirements outlined in Chapter 6 of the Regulation.

Pharmacist. A person who is trained specially in the scientific basis of pharmacology and who is licensed to prepare and sell or dispense drugs and compounds and to make up prescriptions ordered by a physician.

Physical Medicine Services or Physiatry Services. The treatment of disease or injury by physical means such as massage, hydrotherapy, or heat.

Physical Handicap. A physical condition of the body that meets the following criteria:

1. Duration. The condition is expected to result in death, or has lasted, or with reasonable certainty is expected to last, for a minimum period of 12 months; and

2. Extent. The condition is of such severity as to preclude the individual from engaging in substantially basic productive activities of daily living expected of unimpaired persons of the same age group.

Physical Therapist. A person who is trained specially in the skills and techniques of physical therapy (that is, the treatment of disease by physical agents and methods such as heat, massage, manipulation, therapeutic exercise, hydrotherapy, and various forms of energy such as electrotherapy and ultra- sound), who has been authorized legally (that is, registered) to administer treatments prescribed by a physician and who is entitled legally to use the designation "Registered Physical Therapist." A physical therapist also may be called a physiotherapist.

Physician. A person with a degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is licensed to practice medicine by an appropriate authority.

Physician in Training. Interns, residents, and fellows participating in approved postgraduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital or other institutional provider setting, e.g., individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools.

Podiatrist (Doctor of Podiatry or Surgical Chiropody). A person who has received a degree in podiatry (formerly called chiropody), that is, that specialized field of the healing arts that deals with the study and care of the foot, including its anatomy, pathology, and medical and surgical treatment.

Preauthorization. A decision issued in writing by the Director, OCHAMPUS, or a designee, that CHAMPUS benefits are payable for certain services that a beneficiary has not yet received.

Prescription Drugs and Medicines. Drugs and medicines which at the time of use were approved for commercial marketing by the U.S. Food and Drug Administration, and which, by law of the United States, require a physician's or dentist's prescription, except that it includes insulin for known diabetics whether or not a prescription is required. Drugs grandfathered by the Federal Food, Drug and Cosmetic Act of 1938 may be covered under CHAMPUS as if FDA approved.

NOTE: The fact that the U.S. Food and Drug Administration has approved a drug for testing on humans would not qualify it within this definition.

Preventive Care. Diagnostic and other medical procedures not related directly to a specific illness, injury, or definitive set of symptoms, or obstetrical care, but rather performed as periodic health screening, health assessment, or health maintenance.

Primary Payer. The plan or program whose medical benefits are payable first in a double coverage situation.

Private Duty (Special) Nursing Services. Skilled nursing services rendered to an individual patient requiring intensive medical care. Such private duty (special) nursing must be by an actively practicing registered nurse (R.N.) or licensed practical or vocational nurse (L.P.N. or L.V.N.) only when the medical condition of the patient requires intensive skilled nursing services (rather than primarily providing the essentials of daily living) and when such skilled nursing care is ordered by the attending physician.

Private Room. A room with one bed that is designated as a private room by the hospital or other authorized institutional provider.

Program for the Handicapped (PFTH). The special program set forth in Chapter 5 of this Regulation, through which dependents of active duty members receive supplemental benefits for the moderately or severely mentally retarded and the seriously physically handicapped over and above those medical benefits available under the Basic Program.

Progress notes. Progress notes are an essential component of the medical record wherein health care personnel provide written evidence of ordered and supervised diagnostic tests, treatments, medical procedures, therapeutic behavior and outcomes. In the case of mental health care, progress notes must include: the date of the therapy session; length of the therapy session; a notation of the patient's signs and symptoms; the issues, pathology and specific behaviors addressed in the therapy session; a statement summarizing the therapeutic interventions attempted during the therapy session; descriptions of the response to treatment, the outcome of the treatment, and the response to significant others; and a statement summarizing the patient's degree of progress toward the treatment goals. Progress notes do not need to repeat all that was said during a therapy session but must document a patient contact and be sufficiently detailed to allow for both peer review and audits to substantiate the quality and quantity of care rendered.

Prosthetic Device (Prosthesis). An artificial substitute for a missing body part.

Provider. A hospital or other institutional provider, a physician, or other individual professional provider, or other provider of services or supplies as specified in Chapter 6 of this Regulation.

Provider Exclusion and Suspension. The terms "exclusion" and "suspension", when referring to a provider under CHAMPUS, both mean the denial of status as an authorized provider, resulting in items, services, or supplies furnished by the provider not being reimbursed, directly or indirectly, under CHAMPUS. The terms may be used interchangeably to refer to a provider who has been denied status as an authorized CHAMPUS provider based on 1) a criminal conviction or civil judgment involving fraud, 2) an administrative finding of fraud or abuse under CHAMPUS, 3) an administrative finding that the provider has been excluded or suspended by another agency of the Federal Government, a state, or a local licensing authority, 4) an administrative finding that the provider has knowingly participated in a conflict of interest situation, or 5) an administrative finding that it is in the best interests of the CHAMPUS or CHAMPUS beneficiaries to exclude or suspend the provider.

Provider Termination. When a provider's status as an authorized CHAMPUS provider is ended, other than through exclusion or suspension, based on a finding that the provider does not meet the qualifications, as set forth in Chapter 6 of this Regulation, to be an authorized CHAMPUS provider.

Psychiatric Emergency. A psychiatric inpatient admission is an emergency when, based on a psychiatric evaluation performed by a physician (or other qualified mental health care professional with hospital admission authority), the patient is at immediate risk of serious harm to self or others as a result of a mental disorder and requires immediate continuous skilled observation at the acute level of care.

Radiation Therapy Services. The treatment of diseases by x-ray, radium, or radioactive isotopes when ordered by the attending physician.

Referral. The act or an instance of referring a CHAMPUS beneficiary to another authorized provider to obtain necessary medical treatment. Under CHAMPUS, only a physician may make referrals.

Registered Nurse. A person who is prepared specially in the scientific basis of nursing, who is a graduate of a school of nursing, and who is registered for practice after examination by a state board of nurse examiners or similar regulatory authority, who holds a current, valid license, and who is entitled legally to use the designation R.N.

Representative. Any person who has been appointed by a party to the initial determination as counsel or advisor and who is otherwise eligible to serve as the counsel or advisor of the party to the initial determination, particularly in connection with a hearing.

Resident (Medical). A graduate physician or dentist who has an M.D. or D.O. degree, or D.D.S. or D.M.D. degree, respectively, is licensed to practice, and who chooses to remain on the house staff of a hospital to get further training that will qualify him or her for a medical or dental specialty.

Residential Treatment Center (RTC). A facility (or distinct part of a facility) which meets the criteria in Chapter 6.B.4.

Retiree. A member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay based on duty in a Uniformed Service.

Routine Eye Examinations. The services rendered in order to determine the refractive state of the eyes.

Sanction. For purpose of Chapter 9, "sanction" means a provider exclusion, suspension, or termination.

Secondary Payer. The plan or program whose medical benefits are payable in double coverage situations only after the primary payer has adjudicated the claim.

Semiprivate Room. A room containing at least two beds. If a room is designated publicly as a semiprivate accommodation by the hospital or other authorized institutional provider and contains multiple beds, it qualifies as a semiprivate room for the purposes of CHAMPUS.

Skilled Nursing Facility. An institution (or a distinct part of an institution) that meets the criteria as set forth in subsection B.4. of Chapter 6 of this Regulation.

Skilled Nursing Service. A service that can only be furnished by an R.N., or L.P.N. or L.V.N., and is required to be performed under the supervision of a physician to ensure the safety of the patient and achieve the medically desired result. Examples of skilled nursing services are intravenous or intramuscular injections, levin tube or gastrostomy feedings, or tracheotomy aspiration and insertion. Skilled nursing services are other than those services that provide primarily support for the essentials of daily living or that could be performed by an untrained adult with minimum instruction or supervision.

Specialized Treatment Service Facility. A military or civilian medical treatment facility specifically designated pursuant to Chapter 4, paragraph A.10, to be a referral facility for certain highly specialized care. For this purpose, a civilian medical treatment facility may be another federal facility (such as a Department of Veterans Affairs hospital).

Special Tutoring. Teaching or instruction provided by a private teacher to an individual usually in a private or separate setting to enhance the educational development of an individual in one or more study areas.

Spectacles, Eyeglasses, and Lenses. Lenses, including contact lenses, that help to correct faulty vision.

Sponsor. An active duty member, retiree, or deceased active duty member or retiree, of a Uniformed Service upon whose status his or her dependents' eligibility for CHAMPUS is based.

Spouse. A lawful wife or husband regardless of whether or not dependent upon the active duty member or retiree.

Student Status. A dependent of a member or former member of a Uniformed Service who has not passed his or her 23rd birthday, and is enrolled in a full-time course of study in an institution of higher learning.

Suppliers of Portable X-Ray Services. A supplier that meets the conditions of coverage of the Medicare program, set forth in the Medicare regulations (reference (m)), or the Medicaid program in the state in which the covered service is provided.

Surgery. Medically appropriate operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and those certain procedures listed in paragraph C.2.a. of Chapter 4 of this Regulation.

Surgical Assistant. A physician (or dentist or podiatrist) who assists the operating surgeon in the performance of a covered surgical service when such assistance is certified as necessary by the attending surgeon, when the type of surgical procedure being performed is of such complexity and seriousness as to require a surgical assistant, and when interns, residents, or other house staff are not available to provide the surgical assistance services in the specialty area required.

Suspension of Claims Processing. The temporary suspension of processing (to protect the government's interests) of claims for care furnished by a specific provider (whether the claims are submitted by the provider or beneficiary) or claims submitted by or on behalf of a specific CHAMPUS beneficiary pending action by the Director, OCHAMPUS, or a designee, in a case of suspected fraud or abuse. The action may include the administrative remedies provided for in Chapter 9 or any other Department of Defense issuance (e.g. DoD issuances implementing the Program Fraud Civil Remedies Act), case development or investigation by OCHAMPUS, or referral to the Department of Defense-Inspector General or the Department of Justice for action within their cognizant jurisdictions.

Teaching Physician. A teaching physician is any physician whose duties include providing medical training to physicians in training within a hospital or other institutional provider setting.

Timely Filing. The filing of CHAMPUS claims within the prescribed time limits as set forth in Chapter 7 of this Regulation.

Treatment Plan. A detailed description of the medical care being rendered or expected to be rendered a CHAMPUS beneficiary seeking approval for inpatient benefits for which preauthorization is required as set forth in section B. of Chapter 4 of this Regulation. A treatment plan must include, at a minimum, a diagnosis (either ICD-9-CM or DSM-III); detailed reports of prior treatment, medical history, family history, social history, and physical examination; diagnostic test results; consultant's reports (if any); proposed treatment by type (such as surgical, medical, and psychiatric); a description of who is or will be providing treatment (by discipline or specialty); anticipated frequency, medications, and specific goals of treatment; type of inpatient facility required and why (including length of time the related inpatient stay will be required); and prognosis. If the treatment plan involves the transfer of a CHAMPUS patient from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the treatment plan documentation.

Uniformed Services. The Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA.

Veteran. A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

NOTE: Unless the veteran is eligible for "retired pay," "retirement pay," or "retainer pay," which refers to payments of a continuing nature and are payable at fixed intervals from the government for military service neither the veteran nor his or her dependents are eligible for benefits under CHAMPUS.

Well-Baby Care. A specific program of periodic health screening, developmental assessment, and routine immunization for children from birth up to 2 years.

Widow or Widower. A person who was a spouse at the time of death of the active duty member or retiree and who has not remarried.

Worker's Compensation Benefits. Medical benefits available under any worker's compensation law (including the Federal Employees Compensation Act), occupational disease law, employers liability law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure.

X-Ray Services. An x-ray examination from which an x-ray film or other image is produced, ordered by the attending physician when necessary and rendered in connection with a medical or surgical diagnosis or treatment of an illness or injury, or in connection with maternity or well-baby care.

CHAPTER 4

BASIC PROGRAM BENEFITS

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CHAPTER 4
BASIC PROGRAM BENEFITS

A. GENERAL

The CHAMPUS Basic Program is essentially a supplemental program to the Uniformed Services direct medical care system. The Basic Program is similar to private medical insurance programs, and is designed to provide financial assistance to CHAMPUS beneficiaries for certain prescribed medical care obtained from civilian sources.

1. Scope of benefits. Subject to all applicable definitions, conditions, limitations, or exclusions specified in this Regulation, the CHAMPUS Basic Program will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury, including maternity care and well-baby care. Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians, other authorized individual professional providers, and professional ambulance service, prescription drugs, authorized medical supplies, and rental or purchase of durable medical equipment.

2. Persons eligible for Basic Program benefits. Persons eligible to receive the Basic Program benefits are set forth in Chapter 3 of this Regulation. Any person determined to be an eligible CHAMPUS beneficiary is eligible for Basic Program benefits.

3. Authority to act for CHAMPUS. The authority to make benefit determinations and authorize the disbursement of funds under CHAMPUS is restricted to the Director, OCHAMPUS; designated OCHAMPUS staff; Director, OCHAMPUSEUR; or CHAMPUS fiscal intermediaries. No other persons or agents (such as physicians, staff members of hospitals, or CHAMPUS health benefits advisors) have such authority.

4. Status of patient controlling for purposes of cost-sharing. Benefits for covered services and supplies described in this chapter will be extended either on an inpatient or outpatient cost-sharing basis in accordance with the status of the patient at the time the covered services and supplies were provided, unless otherwise specifically designated (such as for ambulance service or maternity care). For cost-sharing provisions, refer to section F. of this chapter.

5. Right to information. As a condition precedent to the provision of benefits hereunder, OCHAMPUS or its CHAMPUS fiscal intermediaries shall be entitled to receive information from a physician or hospital or other person, institution, or organization (including a local, state, or U.S. Government agency) providing services or supplies to the beneficiary for which claims or requests for approval for benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, or examination or diagnosis of, or treatment rendered, or services and supplies furnished to a beneficiary, and shall be necessary for the accurate and efficient administration of CHAMPUS benefits. Before a determination will be made on a request for preauthorization or claim of benefits, a beneficiary or sponsor must provide particular additional information relevant to the requested determina-

tion, when necessary. The recipient of such information shall in every case hold such records confidential except when (a) disclosure of such information is authorized specifically by the beneficiary; (b) disclosure is necessary to permit authorized governmental officials to investigate and prosecute criminal actions, or (c) disclosure is authorized or required specifically under the terms of the Privacy Act or Freedom of Information Act (references (i) through (k)) (refer to section M. of chapter 1 of this Regulation). For the purposes of determining the applicability of and implementing the provisions of chapters 8, 11 and 12, or any provision of similar purpose of any other medical benefits coverage or entitlement, OCHAMPUS or CHAMPUS fiscal intermediaries may release, without consent or notice to any beneficiary or sponsor, to any person, organization, government agency, provider, or other entity any information with respect to any beneficiary when such release constitutes a routine use published in the Federal Register in accordance with DoD 5400.11-R (reference (k)). Before a person's claim of benefits will be adjudicated, the person must furnish to CHAMPUS information that reasonably may be expected to be in his or her possession and that is necessary to make the benefit determination. Failure to provide the requested information may result in denial of the claim.

6. Physical examinations. The Director, OCHAMPUS, or a designee, may require a beneficiary to submit to one or more medical (including psychiatric) examinations to determine the beneficiary's entitlement to benefits for which application has been made or for otherwise authorized medically necessary services and supplies required in the diagnosis or treatment of an illness or injury (including maternity and well-baby care). When a medical examination has been requested, CHAMPUS will withhold payment of any pending claims or preauthorization requests on that particular beneficiary. If the beneficiary refuses to agree to the requested medical examination, or unless prevented by a medical reason acceptable to OCHAMPUS, the examination is not performed within 90 days of initial request, all pending claims for services and supplies will be denied. A denial of payments for services or supplies provided before (and related to) the request for a physical examination is not subject to reconsideration. The medical examination and required beneficiary travel related to performing the requested medical examination will be at the expense of CHAMPUS. The medical examination may be performed by a physician in a Uniformed Services medical facility or by an appropriate civilian physician, as determined and selected by the Director, OCHAMPUS, or a designee who is responsible for making such arrangements as are necessary, including necessary travel arrangements.

7. Claims filing deadline. For all services provided on or after January 1, 1993, to be considered for benefits, all claims submitted for benefits, must, except as provided in Chapter 7, of this regulation, be filed with the appropriate CHAMPUS contractor no later than one year after the services are provided. Unless the requirement is waived, failure to file a claim within the deadline waives all rights to benefits for such services or supplies.

8. Double coverage and third party recoveries. CHAMPUS claims involving double coverage or the possibility that the United States can recover all or a part of its expenses from a third party, are specifically subject to the provisions of Chapter 8 or Chapter 12 of this Regulation as appropriate.

9. Nonavailability Statements within a 40-mile catchment area. In some geographic locations (or under certain special circumstances), it is necessary for a CHAMPUS beneficiary to determine whether the required medical care can be provided through a Uniformed Service facility. If the required medical care cannot be provided, the hospital commander, or a designee, will issue a Nonavailability Statement (DD Form 1251). Except for emergencies, a Nonavailability Statement should be issued before medical care is obtained from a civilian source. Failure to secure such a statement may waive the beneficiary's rights to benefits under CHAMPUS.

a. Rules applicable to issuance of Nonavailability Statement (DD Form 1251).

(1) The ASD(HA) is responsible for issuing rules and regulations regarding Nonavailability Statements.

(2) A Nonavailability Statement (NAS) is required for services in connection with nonemergency inpatient hospital care if such services are available at a facility of the Uniformed Services located within a 40-mile radius of the residence of the beneficiary, except that a NAS is not required for services otherwise available at a facility of the Uniformed Services located within a 40-mile radius of the beneficiary's residence when another insurance plan or program provides the beneficiary primary coverage for the services.

(3) An NAS is also required for selected outpatient procedures if such services are not available at a Uniformed Service facility (excluding facilities which are exclusively outpatient clinics) located within a 40-mile radius (catchment area) of the residence of the beneficiary. This does not apply to emergency services or for services for which another insurance plan or program provides the beneficiary primary coverage. Any changes to the selected outpatient procedures will be published in the Federal Register at least 30 days before the effective date of the change by the ASD(HA) and will be limited to the following categories: outpatient surgery and other selected outpatient procedures which have high unit costs and for which care may be available in military treatment facilities generally. The selected outpatient procedures will be uniform for all CHAMPUS beneficiaries.

(4) In addition to NAS requirements set forth in paragraph A.9, of this chapter, additional NAS requirements are established pursuant to paragraph A.10, of this chapter in connection with highly specialized care in national or 200 mile catchment areas of military or civilian Specialized Treatment Services Facilities.

b. Beneficiary responsibility. The beneficiary is responsible for securing information whether or not he or she resides in a geographic area that requires obtaining a Nonavailability Statement. Information concerning current rules and regulations may be obtained from the Offices of the Army, Navy, and Air Force Surgeon Generals; or a CHAMPUS health benefits advisor; or the Director, OCHAMPUS, or a designee; or from the appropriate CHAMPUS fiscal intermediary.

c. Rules in effect at time civilian medical care is provided apply. The applicable rules and regulations regarding Nonavailability Statements in effect at the time the civilian care is rendered apply in determining whether a Nonavailability Statement is required.

d. Nonavailability Statement (DD Form 1251) must be filed with applicable claim. When a claim is submitted for CHAMPUS benefits that includes services for which a Nonavailability Statement was issued, a valid Nonavailability Statement authorization must be on DEERS.

e. Nonavailability Statement (NAS) and claims adjudication.

(1) A NAS is valid for the adjudication of CHAMPUS claims for all related care otherwise authorized by this Regulation which is received from a civilian source while the beneficiary resided within the Uniformed Service facility catchment area which issued the NAS.

(2) A requirement for a NAS for inpatient hospital maternity care must be met for CHAMPUS cost-share of any related outpatient maternity care.

10. Nonavailability Statements in national or 200-mile catchment areas for highly specialized care available in selected military or civilian Specialized Treatment Service Facilities.

a. Specialized Treatment Service Facilities. STS Facilities may be designated for certain high cost, high technology procedures. The purpose of such designations is to concentrate patient referrals for certain highly specialized procedures which are of relatively low incidence and/or relatively high per case cost and which require patient concentration to permit resource investment and enhance the effectiveness of quality assurance efforts.

b. Designation. Selected military treatment facilities and civilian facilities will be designated by the Assistant Secretary of Defense for Health Affairs as STS Facilities for certain procedures. These designations will be based on the highly specialized capabilities of these selected facilities. For each STS designation for which NASs in national or 200-mile catchment areas will be required, there shall be a determination that total government costs associated with providing the service under the Specialized Treatment Services program will in aggregate be less than the total government cost of that service under the normal operation of CHAMPUS. There shall also be a determination that the Specialized Treatment Services Facility meets a standard of excellence in quality comparable to that prevailing in other specialized medical centers in the nation or region that provide the services involved.

c. Organ transplants and similar procedures. For organ transplants and procedures of similar extraordinary specialization, military or civilian STS Facilities may be designated for a nationwide catchment area, covering all 50 states, the District of Columbia and Puerto Rico (or, alternatively, for any portion of such a nationwide area).

d. Other highly specialized procedures. For other highly specialized procedures, military or civilian STS Facilities will be designated for catchment areas of up to approximately 200 miles radius. The exact geographical area covered for each STS Facility will be identified by reference to State and local

governmental jurisdictions, zip code groups or other method to describe an area within an approximate radius of 200 miles from the facility. In paragraph A.10 of this chapter, this catchment area is referred to as a "200-mile catchment area".

e. NAS requirement. For procedures subject to a nationwide catchment area NAS requirement under paragraph A.10.c of this chapter or a 200-mile catchment area NAS requirement under paragraph A.10.d of this chapter CHAMPUS cost sharing is not allowed unless the services are obtained from a designated civilian Specialized Treatment Services program (as authorized) or an NAS has been issued. This rule is subject to the exception set forth in paragraph A.10.f of this chapter. This NAS requirement is a general requirement of the CHAMPUS program.

f. Exceptions. Nationwide catchment area NASs and 200-mile catchment area NASs are not required in any of the following circumstances:

- (1) An emergency.
- (2) When another insurance plan or program provides the beneficiary primary coverage for the services.
- (3) A case-by-case waiver is granted based on a medical judgment made by the commander of the STS Facility (or other person designated for this purpose) that, although the care is available at the facility, it would be medically inappropriate because of a delay in the treatment or other special reason to require that the STS Facility be used; or
- (4) A case-by-case waiver is granted by the commander of the STS Facility (or other person designated for this purpose) that, although the care is available at the facility, use of the facility would impose exceptional hardship on the beneficiary or the beneficiary's family.

g. Waiver process. A process shall be established for beneficiaries to request a case-by-case waiver under paragraphs A.10.f.(3)(4) of this chapter. This process shall include:

- (1) An opportunity for the beneficiary (and/or the beneficiary's physician) to submit information the beneficiary believes justifies a waiver.
- (2) A written decision from a person designated for the purpose on the request for a waiver, including a statement of the reasons for the decision.
- (3) An opportunity for the beneficiary to appeal an unfavorable decision to a designated appeal authority not involved in the initial decision; and
- (4) A written decision on the appeal, including a statement of the reasons for the decision.

h. Notice. The Assistant Secretary of Defense for Health Affairs will annually publish in the Federal Register a notice of all military and civilian STS Facilities, including a listing of the several procedures subject to nationwide catchment area NASs and the highly specialized procedures subject to 200-mile catchment area NASs.

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RESERVED

i. Specialized procedures. Highly specialized procedures that may be established as subject to 200-mile catchment area NASs are limited to:

(1) Medical and surgical diagnoses requiring inpatient hospital treatment of an unusually intensive nature, documented by a DRG-based payment system weight (pursuant to Chapter 14, paragraph A.1) for a single DRG or an aggregated DRG weight for a category of DRGs of at least 2.0 (i.e., treatment is at least two times as intensive as the average CHAMPUS inpatient case).

(2) Diagnostic or therapeutic services, including outpatient services, related to such inpatient categories of treatment.

(3) Other procedures which require highly specialized equipment the cost of which exceeds \$1,000,000 (e.g., lithotripter, positron emission tomography equipment) and such equipment is underutilized in the area; and

(4) Other comparable highly specialized procedures as determined by the Assistant Secretary of Defense for Health Affairs.

j. Quality standards. Any facility designated as a military or civilian STS Facility under paragraph A.10 of this chapter shall be required to meet quality standards established by the Assistant Secretary of Defense for Health Affairs. In the development of such standards, the Assistant Secretary shall consult with relevant medical speciality societies and other appropriate parties. To the extent feasible, quality standards shall be based on nationally recognized standards.

k. NAS procedures. The provisions of paragraphs A.9.b through A.9.e of this chapter regarding procedures applicable to NASs shall apply to expanded catchment area NASs required by paragraph A.10 of this chapter.

l. Travel and lodging expenses. In accordance with guidelines issued by the Assistant Secretary of Defense for Health Affairs, certain travel and lodging expenses associated with services under the Specialized Treatment Services program may be fully or partially reimbursed.

m. Preference for military facility use. In any case in which services subject to an NAS requirement under paragraph A.10 of this chapter are available in both a military STS Facility and from a civilian STS Facility, the military Facility must be used unless use of the civilian Facility is specifically authorized.

11. Quality and Utilization Review Peer Review Organization program. All benefits under the CHAMPUS program are subject to review under the CHAMPUS Quality and Utilization Review Peer Review Organization program pursuant to Chapter 15. Utilization and quality review of mental health services are also part of the Peer Review Organization program, and are addressed in paragraph A.12 of this chapter.)

12. Utilization review, quality assurance and preauthorization for inpatient mental health services.

a. In general. The Director, OCHAMPUS shall provide, either directly or through contract, a program of utilization and quality review for all mental health care services. Among other things, this program shall include mandatory

preadmission authorization before nonemergency inpatient mental health services may be provided and mandatory approval of continuation of inpatient services within 72 hours of emergency admissions. This program shall also include requirements for other pretreatment authorization procedures, concurrent review of continuing inpatient and partial hospitalization care, retrospective review, and other such procedures as determined appropriate by the Director, OCHAMPUS. The provisions of paragraph H of this chapter and paragraph F, Chapter 15, shall apply to this program. The Director, OCHAMPUS, shall establish, pursuant to paragraph F., Chapter 15, procedures substantially comparable to requirements of paragraph H of this chapter and Chapter 15. If the utilization and quality review program for mental health care services is provided by contract, the contractor(s) need not be the same contractor(s) as are engaged under Chapter 15 in connection with the review of other services.

b. Preadmission authorization.

(1) This section generally requires preadmission authorization for all nonemergency inpatient mental health services and prompt continued stay authorization after emergency admissions. It also requires preadmission authorization for all admissions to a partial hospitalization program, without exception, as the concept of an emergency admission does not pertain to a partial hospitalization level of care. Institutional services for which payment would otherwise be authorized, but which were provided without compliance with preadmission authorization requirements, do not qualify for the same payment that would be provided if the preadmission requirements had been met.

(2) In cases of noncompliance with preauthorization requirements, a payment reduction shall be made in accordance with Chapter 15, paragraph B.4.c.

(3) For purposes of paragraph A.12.b.(2) of this chapter, a day of services without the appropriate preauthorization is any day of services provided prior to:

(a) the receipt of an authorization; or

(b) the effective date of an authorization subsequently received.

(4) Services for which payment is disallowed under paragraph A.12.b.(2) of this chapter may not be billed to the patient (or the patient's family).

13. Implementing instructions. The Director, OCHAMPUS, shall issue policies, procedures, instructions, guidelines, standards, and/or criteria to implement this chapter.

B. INSTITUTIONAL BENEFITS

1. General. Services and supplies provided by an institutional provider authorized as set forth in Chapter 6 of this Regulation may be cost-shared only when such services or supplies (i) are otherwise authorized by this Regulation; (ii) are medically necessary; (iii) are ordered, directed, prescribed, or delivered by an

OCHAMPUS-authorized individual professional provider as set forth in Chapter 6 of this Regulation or by an employee of the authorized institutional provider who is otherwise eligible to be a CHAMPUS authorized individual professional provider; (iv) are delivered in accordance with generally accepted norms for clinical practice in the United States; (v) meet established quality standards; and (vi) comply with applicable definitions, conditions, limitations, exceptions, or exclusions as otherwise set forth in this Regulation.

a. Billing practices. To be considered for benefits under this section B., covered services and supplies must be provided and billed for by a hospital or other authorized institutional provider. Such billings must be fully itemized and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. Depending on the individual circumstances, teaching physician services may be considered an institutional benefit in accordance with this Section or a professional benefit under Section C. See paragraph C.3.m. of the Chapter for the CHAMPUS requirements regarding teaching physicians. In the case of continuous care, claims shall be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor or, on a participating basis, directly by the facility on behalf of the beneficiary (refer to Chapter 7).

b. Successive inpatient admissions. Successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the active duty dependent's share of the inpatient institutional charges, provided not more than 60 days have elapsed between the successive admissions, except that successive inpatient admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions. For the purpose of applying benefits, successive admissions will be determined separately for maternity admissions and admissions related to an accidental injury (refer to section F. of this chapter).

c. Related services and supplies. Covered services and supplies must be rendered in connection with and related directly to a covered diagnosis or definitive set of symptoms requiring otherwise authorized medically necessary treatment.

d. Inpatient, appropriate level required. For purposes of inpatient care, the level of institutional care for which Basic Program benefits may be extended must be at the appropriate level required to provide the medically necessary treatment except for patients requiring skilled nursing facility care. For patients for whom skilled nursing facility care is adequate, but is not available in the general locality, benefits may be continued in the higher level care facility. General locality means an area that includes all the skilled nursing facilities within 50 miles of the higher level facility, unless the higher level facility can demonstrate that the skilled nursing facilities are inaccessible to its patients. The decision as to whether a skilled nursing facility is within the higher level facility's general locality, or the skilled nursing facility is inaccessible to the higher level facility's patients shall be a CHAMPUS contractor initial determination for the purposes of appeal under chapter 10 of this regulation. CHAMPUS institutional benefit payments shall be limited to the

allowable cost that would have been incurred in the skilled nursing facility, as determined by the Director, OCHAMPUS, or a designee. If it is determined that the institutional care can be provided reasonably in the home setting, no CHAMPUS institutional benefits are payable.

e. General or special education not covered. Services and supplies related to the provision of either regular or special education generally are not covered. Such exclusion applies whether a separate charge is made for education or whether it is included as a part of an overall combined daily charge of an institution. In the latter instance, that portion of the overall combined daily charge related to education must be determined, based on the allowable costs of the educational component, and deleted from the institution's charges before CHAMPUS benefits can be extended. The only exception is when appropriate education is not available from or not payable by the cognizant public entity. Each case must be referred to the Director, OCHAMPUS, or a designee, for review and a determination of the applicability of CHAMPUS benefits.

2. Covered hospital services and supplies

a. Room and board. Includes special diets, laundry services, and other general housekeeping support services (inpatient only).

b. General staff nursing services.

(b) A preliminary treatment plan must be established within 24 hours of the admission.

(c) A master treatment plan must be established within ten calendar days of the admission.

(3) The elements of the individualized treatment plan must include:

(a) The diagnostic evaluation that establishes the necessity for the admission;

(b) An assessment regarding the inappropriateness of services at a less intensive level of care;

(c) A comprehensive, biopsychosocial assessment and diagnostic formulation;

(d) A specific individualized treatment plan that integrates measurable goals/objectives and their required level of care for each of the patient's problems that are a focus of treatment;

(e) A specific plan for involvement of family members, unless therapeutically contraindicated; and

(f) A discharge plan, including an objective of referring the patient to further services, if needed, at less intensive levels of care within the benefit limit period.

(4) Preauthorization requests should be made not fewer than two business days prior to the planned admission. In general, the decision regarding preauthorization shall be made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. Preauthorizations are valid for the period of time, appropriate to the type of care involved, stated when the preauthorization is issued. In general, preauthorizations are valid for 30 days.

i. Concurrent review. Concurrent review of the necessity for continued stay will be conducted no less frequently than every 30 days. The criteria for concurrent review shall be those set forth in paragraph B.4.g. of this chapter. In applying those criteria in the context of concurrent review, special emphasis is placed on evaluating the progress being made in the active individualized clinical treatment being provided and on developing appropriate discharge plans.

5. Extent of institutional benefits

a. Inpatient room accommodations

(1) Semiprivate. The allowable costs for room and board furnished an individual patient are payable for semiprivate accommodations in a hospital or other authorized institution, subject to appropriate cost-sharing

provisions (refer to section F. of this chapter). A semiprivate accommodation is a room containing at least two beds. Therefore, if a room publicly is designated by the institution as a semiprivate accommodation and contains multiple beds, it qualifies as semiprivate for the purpose of CHAMPUS.

(2) Private. A room with one bed that is designated as a private room by the hospital or other authorized institutional provider. The allowable cost of a private room accommodation is covered only under the following conditions:

(a) When its use is required medically and when the attending physician certifies that a private room is necessary medically for the proper care and treatment of a patient; or

(b) When a patient's medical condition requires isolation;

or

(c) When a patient (in need of immediate inpatient care but not requiring a private room) is admitted to a hospital or other authorized institution that has semiprivate accommodations, but at the time of admission, such accommodations are occupied; or

(d) When a patient is admitted to an acute care hospital (general or special) without semiprivate rooms.

(3) Duration of private room stay. The allowable cost of private accommodations is covered under the circumstances described in subparagraph B.5.a.(2) of this chapter until the patient's condition no longer requires the private room for medical reasons or medical isolation; or, in the case of the patient not requiring a private room, when a semiprivate accommodation becomes available; or, in the case of an acute care hospital (general or special) which does not have semiprivate rooms, for the duration of an otherwise covered inpatient stay.

(4) Hospital (except an acute care hospital, general or special) or other authorized institutional provider without semiprivate accommodations. When a beneficiary is admitted to a hospital (except an acute care hospital, general or special) or other institution that has no semiprivate accommodations, for any inpatient day when the patient qualifies for use of a private room (as set forth in subparagraphs B.5.a.(2)(a) and (b), above), the allowable cost of private accommodations is covered. For any inpatient day in such a hospital or other authorized institution when the patient does not require medically the private room, the allowable cost of semiprivate accommodations is covered, such allowable costs to be determined by the Director, OCHAMPUS, or a designee.

b. General staff nursing services. General staff nursing services cover all nursing care (other than that provided by private duty nurses) including, but not limited to, general duty nursing, emergency room nursing, recovery room nursing, intensive nursing care, and group nursing arrangements. Only nursing services provided by nursing personnel on the payroll of the hospital or other authorized institution are eligible under this section B. If a nurse who is not on the payroll of the hospital or other

(4) Treatment services. All services, supplies, equipment and space necessary to fulfill the requirements of each patient's individualized diagnosis and treatment plan (with the exception of the five psychotherapy sessions per week which may be allowed separately for individual or family psychotherapy based upon the provisions of B.10.g. of this chapter.) All mental health services must be provided by a CHAMPUS authorized individual professional provider of mental health services. [Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate but the individual must work under the clinical supervision of a fully qualified mental health provider employed by the PHP.]

g. Social services required. The facility must provide an active social services component which assures the patient appropriate living arrangements after treatment hours, transportation to and from the facility, arrangement of community based support services, referral of suspected child abuse to the appropriate state agencies, and effective after care arrangements, at a minimum.

h. Educational services required. Programs treating children and adolescents must ensure the provision of a state certified educational component which assures that patients do not fall behind in educational placement while receiving partial hospital treatment. CHAMPUS will not fund the cost of educational services separately from the per diem rate. The hours devoted to education do not count toward the therapeutic half or full day program.

i. Family therapy required. The facility must ensure the provision of an active family therapy treatment component which assures that each patient and family participate at least weekly in family therapy provided by the institution and rendered by a CHAMPUS authorized individual professional provider of mental health services. There is no acceptable substitute for family therapy. An exception to this requirement may be granted on a case-by-case basis by the Director, OCHAMPUS, or designee, only if family therapy is clinically contraindicated.

j. Professional mental health benefits limited. Professional mental health benefits are limited to a maximum of one session (60 minutes individual, 90 minutes family) per authorized treatment day not to exceed five sessions in any calendar week. These may be billed separately from the partial hospitalization per diem rate only when rendered by an attending, CHAMPUS-authorized mental health professional who is not an employee of, or under contract with, the partial hospitalization program for purposes of providing clinical patient care.

k. Non-mental health related medical services. Separate billing will be allowed for otherwise covered, non-mental health related medical services.

C. PROFESSIONAL SERVICES BENEFIT

1. General. Benefits may be extended for those covered services described in this section C., that are provided in accordance with good medical practice and established standards of quality by physicians or other authorized individual professional providers, as set forth in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, exceptions, limitations, or exclusion as may be otherwise set forth

in this or other chapters of this Regulation. Except as otherwise specifically authorized, to be considered for benefits under this section C., the described services must be rendered by a physician, or prescribed, ordered, and referred medically by a physician to other authorized individual professional providers. Further, except under specifically defined circumstances, there should be an attending physician in any episode of care. (For example, certain services of a clinical psychologist are exempt from this requirement. For these exceptions, refer to Chapter 6.)

a. Billing practices. To be considered for benefits under this section C., covered professional services must be performed personally by the physician or other authorized individual professional provider, who is other than a salaried or contractual staff member of a hospital or other authorized institution, and who ordinarily and customarily bills on a fee-for-service basis for professional services rendered. Such billings must be itemized fully and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. See paragraph C.3.m. of this Chapter for the requirements regarding the special circumstances for teaching physicians. For continuing professional care, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor, or directly by the physician or other authorized individual professional provider on behalf of a beneficiary (refer to Chapter 7 of this Regulation).

b. Services must be related. Covered professional services must be rendered in connection with and directly related to a covered diagnosis or definitive set of symptoms requiring medically necessary treatment.

2. Covered services of physicians and other authorized individual professional providers

a. Surgery. Surgery means operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and the following procedures:

- Bronchoscopy
- Laryngoscopy
- Thoracoscopy
- Catheterization of the heart
- Arteriograph thoracic lumbar
- Esophagoscopy
- Gastrosocopy
- Proctoscopy
- Sigmoidoscopy
- Peritoneoscopy
- Cystoscopy
- Colonoscopy
- Upper G.I. panendoscopy
- Encephalograph
- Myelography
- Discography
- Visualization of intracranial aneurysm by intracarotid injection of dye, with exposure of carotid artery, unilateral

c. Need for surgical assistance. Surgical assistance is payable only when the complexity of the procedure warrants a surgical assistant (other than the surgical nurse or other such operating room personnel), subject to utilization review. In order for benefits to be extended for surgical assistance service, the primary surgeon may be required to certify in writing to the nonavailability of a qualified intern, resident, or other house physician. When a claim is received for a surgical assistant involving the following circumstances, special review is required to ascertain whether the surgical assistance service meets the medical necessity and other requirements of this section C.

- (1) If the surgical assistance occurred in a hospital that has a residency program in a specialty appropriate to the surgery;
- (2) If the surgery was performed by a team of surgeons;
- (3) If there were multiple surgical assistants; or
- (4) If the surgical assistant was a partner of or from the same group of practicing surgeons as the attending surgeon.

d. Aftercare following surgery. Except for those diagnostic procedures classified as surgery in this section C., and injection and needling procedures involving the joints, the benefit payments made for surgery (regardless of the setting in which it is rendered) include normal aftercare, whether the aftercare is billed for by the physician or other authorized individual professional provider on a global, all-inclusive basis, or billed for separately.

e. Cast and sutures, removal. The benefit payments made for the application of a cast or of sutures normally covers the postoperative care including the removal of the cast or sutures. When the application is made in one geographical location and the removal of the cast or sutures must be done in another geographical location, a separate benefit payment may be provided for the removal. The intent of this provision is to provide a separate benefit only when it is impracticable for the beneficiary to use the services of the provider that applied the cast originally. Benefits are not available for the services of a second provider if those services reasonably could have been rendered by the individual professional provider who applied the cast or sutures initially.

f. Inpatient care, concurrent. Concurrent inpatient care by more than one individual professional provider is covered if required because of the severity and complexity of the beneficiary's condition or because the beneficiary has multiple conditions that require treatment by providers of different specialties. Any claim for concurrent care must be reviewed before extending benefits in order to ascertain the condition of the beneficiary at the time the concurrent care was rendered. In the absence of such determination, benefits are payable only for inpatient care rendered by one attending physician or other authorized individual professional provider.

g. Consultants who become the attending surgeon. A consultation performed within 3 days of surgery by the attending physician is considered a preoperative examination. Preoperative examinations are an integral part of the surgery and a separate benefit is not payable for the consultation. If more than 3 days elapse between the consultation and surgery (performed by the same physician), benefits may be extended for the consultation, subject to review.

h. Anesthesia administered by the attending physician. A separate benefit is not payable for anesthesia administered by the attending physician (surgeon or obstetrician) or dentist, or by the surgical, obstetrical, or dental assistant.

i. Treatment of mental disorders. CHAMPUS benefits for the treatment of mental disorders are payable for beneficiaries who are outpatients or inpatients of CHAMPUS-authorized general or psychiatric hospitals, RTCs, or specialized treatment facilities, as authorized by the Director, OCHAMPUS, or a designee. All such services are subject to review for medical or psychological necessity and for quality of care. The Director, OCHAMPUS, reserves the right to require preauthorization of mental health services. Preauthorization may be conducted by the Director, OCHAMPUS, or a designee. In order to qualify for CHAMPUS mental health benefits, the patient must be diagnosed by a CHAMPUS-authorized licensed, qualified mental health professional to be suffering from a mental disorder, according to the criteria listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Benefits are limited for certain mental disorders, such as specific developmental disorders. No benefits are payable for "Conditions Not Attributable to a Mental Disorder," or V codes. In order for treatment of a mental disorder to be medically or psychologically necessary, the patient must, as a result of a diagnosed mental disorder, be experiencing both physical or psychological distress and an impairment in his or her ability to function in appropriate occupational, educational or social roles. It is generally the degree to which the patient's ability to function is impaired that determines the level of care (if any) required to treat the patient's condition.

(1) Covered diagnostic and therapeutic services. Subject to the requirements and limitations stated, CHAMPUS benefits are payable for the following services when rendered in the diagnosis or treatment of a covered mental disorder by a CHAMPUS-authorized, qualified mental health provider practicing within the scope of his or her license. Qualified mental health providers are: psychiatrists or other physicians; clinical psychologists, certified psychiatric nurse specialists or clinical social workers; and certified marriage and family therapists, pastoral, and mental health counselors, under a physician's supervision. No payment will be made for any service listed in this subparagraph C.3.i.(1) rendered by an individual who does not meet the criteria of Chapter 6 of this Regulation for his or her respective profession, regardless of whether the provider is an independent professional provider or an employee of an authorized professional or institutional provider.

(a) Individual psychotherapy, adult or child. A covered individual psychotherapy session is no more than 60 minutes in length. An individual psychotherapy session of up to 120 minutes in length is payable for crisis intervention.

(b) Group psychotherapy. A covered group psychotherapy session is no more than 90 minutes in length.

(c) Family or conjoint psychotherapy. A covered family or conjoint psychotherapy session is no more than 90 minutes in length. A family or conjoint psychotherapy session of up to 180 minutes in length is payable for crisis intervention.

(d) Psychoanalysis. Psychoanalysis is covered when provided by a graduate or candidate of a psychoanalytic training institution recognized by the American Psychological Association or the American Psychiatric Association and when preauthorized by the Director, OCHAMPUS, or a designee.

1. Private duty (special) nursing. Benefits are available for the skilled nursing services rendered by a private duty (special) nurse to a beneficiary requiring intensive skilled nursing care that can only be provided with the technical proficiency and scientific skills of an R.N. The specific skilled nursing services being rendered are controlling, not the condition of the patient or the professional status of the private duty (special) nurse rendering the services.

(1) Inpatient private duty (special) nursing services are limited to those rendered to an inpatient in a hospital that does not have an ICU. In addition, under specified circumstances, private duty (special) nursing in the home setting also is covered.

(2) The private duty (special) nursing care must be ordered and certified to be medically necessary by the attending physician.

(3) The skilled nursing care must be rendered by a private duty (special) nurse who is neither a member of the immediate family nor is a member of the beneficiary's household.

(4) Private duty (special) nursing care does not, except incidentally, include providing services that provide or support primarily the essentials of daily living or acting as a companion or sitter.

(5) If the private duty (special) nursing care services being performed are primarily those that could be rendered by the average adult with minimal instruction or supervision, the services would not qualify as covered private duty (special) nursing services, regardless of whether performed by an R.N., regardless of whether or not ordered and certified to by the attending physician, and regardless of the condition of the patient.

(6) In order for such services to be considered for benefits, a private duty (special) nurse is required to maintain detailed daily nursing notes, whether the case involves inpatient nursing service or nursing services rendered in the home setting.

(7) Claims for continuing private duty (special) nursing care shall be submitted at least every 30 days. Each claim will be reviewed and the nursing care evaluated whether it continues to be appropriate and eligible for benefits.

(8) In most situations involving private duty (special) nursing care rendered in the home setting, benefits will be available only for a portion of the care, that is, providing benefits only for that time actually required to perform medically necessary skilled nursing services. If full-time private duty (special) nursing services are engaged, usually for convenience or to provide personal services to the patient, CHAMPUS benefits are payable only for that portion of the day during which skilled nursing services are rendered, but in no event is less than 1 hour of nursing care payable in any 24-hour period during which skilled nursing services are determined to have been rendered. Such situations often are

better accommodated through the use of visiting nurses. This allows the personal services that are not coverable by CHAMPUS to be obtained at lesser cost from other than an R.N. Skilled nursing services provided by visiting nurses are covered under CHAMPUS.

NOTE: When the services of an R.N. are not available, benefits may be extended for the otherwise covered services of a L.P.N. or L.V.N.

m. Physicians in a teaching setting.

(1) Teaching Physicians.

(a) General. The services of teaching physicians may be reimbursed on an allowable charge basis only when the teaching physician has established an attending physician relationship between the teaching physician and the services (e.g., services rendered as a consultant, assistant surgeon, etc.). Attending physician services may include both direct patient care services or direct supervision of care provided by a physician in training. In order to be considered an attending physician, the teaching physician must:

1 Review the patient's history and the record of examinations and tests in the institution, and make frequent reviews of the patient's progress; and

2 Personally examine the patient; and

3 Confirm or revise the diagnosis and determine the course of treatment to be followed; and

4 Either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by physicians in training and that the care meets a proper quality level; and

5 Be present and ready to perform any service performed by an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; and

6 Be personally responsible for the patient's care, at least throughout the period of hospitalization.

(b) Direct supervision by an attending physician of care provided by physicians in training. Payment on the basis of allowable charges may be made for the professional services rendered to a beneficiary by his/her attending physician when the attending physician provides personal and identifiable direction to physicians in training who are participating in the care of the patient. It is not necessary that the attending physician be personally present for all services, but the attending physician must be on the provider's premises and available to provide immediate personal assistance and direction if needed.

(c) Individual, personal services. A teaching physician may be reimbursed on an allowable charge basis for any individual, identifiable service rendered to a CHAMPUS beneficiary, so long as the service is a covered service and is normally reimbursed separately, and so long as the patient records substantiate the service.

(d) Who may bill. The services of a teaching physician must be billed by the institutional provider when the physician is employed by the provider or a related entity or under a contract which provides for payment to the physician by the provider or a related entity. Where the teaching physician has no relationship with the provider (except for standard physician privileges to admit patients) and generally treats patients on a fee-for-service basis in the private sector, the teaching physician may submit claims under his/her own provider number.

(2) Physicians in training. Physicians in training in an approved teaching program are considered to be "students" and may not be reimbursed directly by CHAMPUS for services rendered to a beneficiary when their services are provided as part of their employment (either salaried or contractual) by a hospital or other institutional provider. Services of physicians in training may be reimbursed on an allowable charge basis only if:

(a) The physician in training is fully licensed to practice medicine by the state in which the services are performed, and

(b) The services are rendered outside the scope and requirements of the approved training program to which the physician in training is assigned.

D. OTHER BENEFITS

1. General. Benefits may be extended for the allowable charge of those other covered services and supplies described in this section D., which are provided in accordance with good medical practice and established standards of quality by those other authorized providers described in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, limitations, or exclusions as otherwise may be set forth in this or other chapters of this Regulation. To be considered for benefits under this section D., the described services or supplies must be prescribed and ordered by a physician. Other authorized individual professional providers acting within their scope of licensure may also prescribe and order these services and supplies unless otherwise specified in this section D. For example, durable medical equipment and cardiorespiratory monitors can only be ordered by a physician.

2. Billing practices. To be considered for benefits under this Section D., covered services and supplies must be provided and billed for by an authorized provider as set forth in Chapter 6 of this Regulation. Such billing must be itemized fully and described sufficiently, even when CHAMPUS payment is determined under the CHAMPUS DRG-based payment system, so that CHAMPUS can determine whether benefits are authorized by this Regulation. Except for claims subject to the CHAMPUS DRG-based payment system, whenever continuing charges are involved, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days (monthly) either by the beneficiary or sponsor or directly by the provider. For claims subject to the CHAMPUS DRG-based payment system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

3. Other covered services and supplies

a. Blood. If whole blood or plasma (or its derivatives) are provided and billed for by an authorized institution in connection with covered treatment, benefits are extended as set forth in section B. of this chapter. If blood is billed for directly to a beneficiary, benefits may be extended under this section D. in the same manner as a medical supply.

b. Durable medical equipment

(1) Scope of benefit. Subject to the exceptions in paragraphs (2) and (3) below, only durable medical equipment (DME) which is ordered by a physician for the specific use of the beneficiary, and which complies with the definition of "Durable Medical Equipment" in Chapter 2 of this Regulation, and which is not otherwise excluded by this Regulation qualifies as a Basic Program benefit.

(2) Cardiorespiratory monitor exception.

(a) When prescribed by a physician who is otherwise eligible as a CHAMPUS individual professional provider, or who is on active duty with a United States Uniformed Service, an electronic cardiorespiratory monitor, including technical support necessary for the proper use of the monitor, may be cost-shared as durable medical equipment when supervised by the prescribing physician for in-home use by:

1 An infant beneficiary who has had an apparent life-threatening event, as defined in guidelines issued by the Director, OCHAMPUS, or a designee, or,

2 An infant beneficiary who is a subsequent or multiple birth biological sibling of a victim of sudden infant death syndrome (SIDS), or,

3 An infant beneficiary whose birth weight was 1,500 grams or less, or,

4 An infant beneficiary who is a pre-term infant with pathologic apnea, as defined in guidelines issued by the Director, OCHAMPUS, or a designee, or,

(3) Newborn patient in his or her own right. When a newborn infant remains as an inpatient in his or her own right (usually after the mother is discharged), the newborn child becomes the beneficiary and patient and the extended inpatient stay becomes a separate inpatient admission. In such a situation, a new, separate inpatient cost-sharing amount is applied. If a multiple birth is involved (such as twins or triplets) and two or more newborn infants become patients in their own right, a separate inpatient cost-sharing amount must be applied to the inpatient stay for each newborn child who has remained as an inpatient in his or her own right.

c. Outpatient cost-sharing. Dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of 20 percent of the CHAMPUS-determined allowable cost or charge beyond the annual fiscal year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

d. Ambulatory surgery. Notwithstanding the above provisions pertaining to outpatient cost-sharing, dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of \$25 for surgical care that is authorized and received while in an outpatient status and that has been designated in guidelines issued by the Director, OCHAMPUS, or a designee.

e. Psychiatric partial hospitalization services. Institutional and professional services provided under the psychiatric partial hospitalization program authorized by paragraph B.10. of this chapter shall be cost-shared as inpatient services.

3. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees. CHAMPUS beneficiary liability set forth for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. The annual fiscal year deductible for otherwise covered outpatient services or supplies provided retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees, is the same as the annual fiscal year outpatient deductible applicable to dependents of active duty members of rank E-5 or above (refer to paragraph F.2.a.(1) or (2) of this chapter).

b. Inpatient cost-sharing. Cost-sharing amounts for inpatient services shall be as follows:

(1) Services subject to the CHAMPUS DRG-based payment system. The cost-share shall be the lesser of an amount calculated by multiplying a per diem amount for each day of the hospital stay except the day of discharge or 25 percent of the hospital's billed charges. The per diem amount shall be calculated so that total cost-sharing amounts for these beneficiaries is equivalent to 25 percent of the CHAMPUS-determined allowable costs for covered services or supplies provided on an inpatient basis by authorized providers. The per diem amount shall be published annually by CHAMPUS.

(2) Services subject to the mental health per diem payment system. The cost-share is dependent upon whether the hospital is paid a hospital-specific per diem or a regional per diem under the provisions of subsection A.2. of Chapter 14. With respect to care paid for on the basis of a hospital-specific per diem,

the cost-share shall be 25% of the hospital-specific per diem amount. For care paid for on the basis of a regional per diem, the cost share shall be the lower of a fixed daily amount or 25% of the hospital's billed charges. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25% of total payments under the mental health per diem payment system. This fixed daily amount shall be updated annually and published in the Federal Register along with the per diems published pursuant to subparagraph A.2.d.(2) of Chapter 14.

(3) Other services. For services exempt from the CHAMPUS DRG-based payment system and the CHAMPUS mental health per diem payment system and services provided by institutions other than hospitals, the cost-share shall be 25% of the CHAMPUS-determined allowable charges.

c. Outpatient cost-sharing.

(1) For services other than ambulatory surgery services. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees are responsible for payment of 25 percent of the CHAMPUS-determined allowable costs or charges beyond the annual fiscal year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

(2) For services subject to the ambulatory surgery payment method. For services subject to the ambulatory surgery payment method set forth in Chapter 14 D., of this regulation, the cost share shall be the lesser of: 25 percent of the payment amount provided pursuant to Chapter 14.D.; or 25 percent of the center's billed charges.

d. Psychiatric partial hospitalization services. Institutional and professional services provided under the psychiatric partial hospitalization program authorized by paragraph B.10. of this chapter shall be cost-shared as inpatient services.

4. Former spouses. CHAMPUS beneficiary liability set forth for former spouses eligible under the provisions of paragraph B.2.b. of Chapter 3 is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. An eligible former spouse is responsible for the payment of the first \$150 of the CHAMPUS-determined reasonable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year. (Except for services received prior to April 1, 1991, the deductible amount is \$50.00). The former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of any CHAMPUS-eligible children.

b. Inpatient cost-sharing. Eligible former spouses are responsible for the payment of cost-sharing amounts the same as those required for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.

c. Outpatient cost-sharing. Eligible former spouses are responsible for payment of 25 percent of the CHAMPUS-determined reasonable costs or charges beyond the annual fiscal year deductible amount for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

5. Cost-Sharing under the Military-Civilian Health Services Partnership Program. Cost-sharing is dependent upon the type of partnership program entered into, whether external or internal. (See section P. of Chapter 1, for general requirements of the Military-Civilian Health Services Partnership Program.)

a. External Partnership Agreement. Authorized costs associated with the use of the civilian facility will be financed through CHAMPUS under the normal cost-sharing and reimbursement procedures applicable under CHAMPUS.

b. Internal Partnership Agreement. Beneficiary cost-share under internal agreements will be the same as charges prescribed for care in military treatment facilities.

6. Amounts over CHAMPUS-determined allowable costs or charges. It is the responsibility of the CHAMPUS fiscal intermediary to determine allowable costs for services and supplies provided by hospitals and other institutions and allowable charges for services and supplies provided by physicians, other individual professional providers, and other providers. Such CHAMPUS-determined allowable costs or charges are made in accordance with the provisions of Chapter 14. All CHAMPUS benefits, including calculation of the CHAMPUS or beneficiary cost-sharing amounts, are based on such CHAMPUS-determined allowable costs or charges. The effect on the beneficiary when the billed cost or charge is over the CHAMPUS-determined allowable amount is dependent upon whether or not the applicable claim was submitted on a participating basis on behalf of the beneficiary or submitted directly by the beneficiary on a nonparticipating basis and on whether the claim is for inpatient hospital services subject to the CHAMPUS DRG-based payment system. This provision applies to all classes of CHAMPUS beneficiaries.

NOTE: When the provider "forgives" or "waives" any beneficiary liability, such as amounts applicable to the annual fiscal year deductible for outpatient services or supplies, or the inpatient or outpatient cost-sharing as previously set forth in this section, the CHAMPUS-determined allowable charge or cost allowance (whether payable to the CHAMPUS beneficiary or sponsor, or to a participating provider) shall be reduced by the same amount.

a. Participating providers. There are several circumstances under which institutional and individual providers may be Participating Providers, either on a mandatory basis or a voluntary basis. See Chapter 6, A.8. A Participating Provider, whether participating for all claims or on a claim-by-claim basis, must accept the CHAMPUS-determined allowable amount as payment in full for the medical services or supplies provided, and must accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing and deductible amounts paid by or on behalf of the beneficiary as payment in full for the covered medical services or supplies. Therefore, when costs or charges are submitted on a participating basis, the patient is not obligated to pay any amounts disallowed as being over the CHAMPUS-determined allowable cost or charge for authorized services or supplies.

b. Nonparticipating providers. Nonparticipating providers are those providers who do not agree on the CHAMPUS claim form to participate and thereby do not agree to accept the CHAMPUS-determined allowable costs or charges as the full charge. For otherwise covered services and supplies provided by such

nonparticipating CHAMPUS providers, payment is made directly to the beneficiary or sponsor and the beneficiary is liable under applicable law for any amounts over the CHAMPUS-determined allowable costs or charges. CHAMPUS shall have no responsibility for any amounts over allowable costs or charges as determined by CHAMPUS.

7. [Reserved]

8. Cost-sharing for services provided under special discount arrangements.

a. General rule. With respect to services determined by the Director, OCHAMPUS (or designee) to be covered by Chapter 14, section I., the Director, OCHAMPUS (or designee) has authority to establish, as an exception to the cost-sharing amount normally required pursuant to this chapter, a different cost-share amount that appropriately reflects the application of the statutory cost-share to the discount arrangement.

b. Specific applications. The following are examples of applications of the general rule; they are not all inclusive.

(1) In the case of services provided by individual health care professionals and other noninstitutional providers, the cost-share shall be the usual percentage of the CHAMPUS allowable charge determined under Chapter 14, section I.

(2) In the case of services provided by institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under Chapter 14, section A.1. or per-diem amount under Chapter 14, section A.2.), if the discount rate is lower than the pre-set rate, the cost-share amount that would apply for a beneficiary other than an active duty dependent pursuant to the normal pre-set rate would be reduced by the same percentage by which the pre-set rate was reduced in setting the discount rate.

9. Waiver of deductible amounts or cost-sharing not allowed.

a. General rule. Because deductible amounts and cost sharing are statutorily mandated, except when specifically authorized by law (as determined by the Director, OCHAMPUS), a provider may not waive or forgive beneficiary liability for annual deductible amounts or inpatient or outpatient cost-sharing, as set forth in this chapter.

b. Exception for bad debts. This general rule is not violated in cases in which a provider has made all reasonable attempts to effect collection, without success, and determines in accordance with generally accepted fiscal management standards that the beneficiary liability in a particular case is an uncollectible bad debt.

c. Remedies for noncompliance. Potential remedies for noncompliance with this requirement include:

(1) A claim for services regarding which the provider has waived the beneficiary's liability may be disallowed in full, or, alternatively, the amount payable for such a claim may be reduced by the amount of the beneficiary liability waived.

(2) Repeated noncompliance with this requirement is a basis for exclusion of a provider.

G. EXCLUSIONS AND LIMITATIONS

In addition to any definitions, requirements, conditions, or limitations enumerated and described in other chapters of this Regulation, the following specifically are excluded from the Basic Program:

1. Not medically or psychologically necessary. Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or injury, for the diagnosis and treatment of pregnancy, or for well-baby care except as provided in the following paragraph.

2. Unnecessary diagnostic tests. X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms except for cancer screening mammography and cancer screening papanicolaou (PAP) smears provided under the terms and conditions contained in the guidelines adopted by the Director, OCHAMPUS.

3. Institutional level of care. Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.

4. Diagnostic admission. Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.

NOTE: If it is determined that the diagnostic x-ray, laboratory, and pathological services and machine tests performed during such admission were medically necessary and would have been covered if performed on an outpatient basis, CHAMPUS benefits may be extended for such diagnostic procedures only, but cost-sharing will be computed as if performed on an outpatient basis.

5. Unnecessary postpartum inpatient stay, mother or newborn. Postpartum inpatient stay of a mother for purposes of staying with the newborn infant (usually primarily for the purpose of breast feeding the infant) when the infant (but not the mother) requires the extended stay; or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.

6. Therapeutic absences. Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by the Director, OCHAMPUS, or a designee. For cost-sharing provisions refer to Chapter 14, paragraph F.3.

7. Custodial care. Custodial care regardless of where rendered, except as otherwise specifically provided in paragraphs E.12.b., E.12.c. and E.12.d. of this chapter.

8. Domiciliary care. Inpatient stays primarily for domiciliary care purposes.

9. Rest or rest cures. Inpatient stays primarily for rest or rest cures.

10. Amounts above allowable costs or charges. Costs of services and supplies to the extent amounts billed are over the CHAMPUS determined allowable cost or charge, as provided for in Chapter 14.

11. No legal obligation to pay, no charge would be made. Services or supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary or sponsor was not eligible under CHAMPUS; or whenever CHAMPUS is a secondary payer for claims subject to the CHAMPUS DRG-based payment system, amounts, when combined with the primary payment, which would be in excess of charges (or the amount the provider is obligated to accept as payment in full, if it is less than the charges).

12. Furnished without charge. Services or supplies furnished without charge.

13. Furnished by local, state, or Federal Government. Services and supplies paid for, or eligible for payment, directly or indirectly by a local, state, or Federal Government, except as provided under CHAMPUS, or by government hospitals serving the general public, or medical care provided by a Uniformed Service medical care facility, or benefits provided under title XIX of the Social Security Act (Medicaid) (reference (h)) (refer to Chapter 8 of this Regulation).

14. Study, grant, or research programs. Services and supplies provided as a part of or under a scientific or medical study, grant, or research program.

- d. Rh immune globulin.
- e. Genetic tests as specified in paragraph E.3.b. of this chapter.
- f. Immunizations and physical examinations provided when required in the case of dependents of active duty military personnel who are traveling outside the United States as a result of an active member's duty assignment and such travel is being performed under orders issued by a Uniformed Service.
- g. Screening mammography for asymptomatic women 35 years of age and older when provided under the terms and conditions contained in the guidelines adopted by the Director OCHAMPUS.
- h. Cancer screening papanicolaou (PAP) smear for women who are or have been sexually active, and women 18 years of age and older under the terms and conditions contained in the guidelines adopted by the Director, OCHAMPUS.

38. Chiropractors and naturopaths. Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider.

39. Counseling. Counseling services that are not medically necessary in the treatment of a diagnosed medical condition; for example, educational counseling, vocational counseling, nutritional counseling, counseling for socio-economic purposes, diabetic self-education programs, stress management, life style modification, etc. Services provided by a certified marriage and family therapist, pastoral or mental health counselor in the treatment of a mental disorder are covered only as specifically provided in Chapter 6. Services provided by alcoholism rehabilitation counselors and certified addiction counselors are covered only when rendered in a CHAMPUS-authorized treatment setting and only when the cost of those services is included in the facility's CHAMPUS-determined allowable cost-rate.

40. Acupuncture. Acupuncture, whether used as a therapeutic agent or as an anesthetic.

41. Hair transplants, wigs, or hairpieces

NOTE: In accordance with Section 744 of the DoD Appropriation Act for 1981 (reference (o)), CHAMPUS coverage for wigs or hairpieces is permitted effective December 15, 1980, under the conditions listed below. Continued availability of benefits will depend on the language of the annual DoD Appropriation Acts.

a. Benefits provided. Benefits may be extended, in accordance with the CHAMPUS-determined allowable charge, for one wig or hairpiece per beneficiary (lifetime maximum) when the attending physician certifies that alopecia has resulted from treatment of a malignant disease and the beneficiary certifies that a wig or hairpiece has not been obtained previously through the U.S. Government (including the Veterans Administration).

b. Exclusions. The wig or hairpiece benefit does not include coverage for the following:

- (1) Alopecia resulting from conditions other than treatment of malignant disease.

(2) Maintenance, wig or hairpiece supplies, or replacement of the wig or hairpiece.

(3) Hair transplants or any other surgical procedure involving the attachment of hair or a wig or hairpiece to the scalp.

(4) Any diagnostic or therapeutic method or supply intended to encourage hair regrowth.

42. Education or training. Self-help, academic education or vocational training services and supplies, unless the provisions of Chapter 4, paragraph B.1.e., relating to general or special education, apply.

43. Exercise/Relaxation/Comfort Devices. Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

44. Exercise. General exercise programs, even if recommended by a physician and regardless of whether or not rendered by an authorized provider. In addition, passive exercises and range of motion exercises also are excluded, except when prescribed by a physician and rendered by a physical therapist concurrent to, and as an integral part of, a comprehensive program of physical therapy.

45. Audiologist, speech therapist. Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of treatment addressed to the physical defect itself and not to any educational or occupational deficit.

46. Vision care. Eye exercises or visual training (orthoptics).

47. Eye and hearing examinations. Eye and hearing examinations except as specifically provided in paragraph C.2.p. of this chapter or except when rendered in connection with medical or surgical treatment of a covered illness or injury. Vision and hearing screening in connection with well-baby care is not excluded.

48. Prosthetic devices. Prostheses, except artificial limbs and eyes, or if an item is inserted surgically in the body as an integral part of a surgical procedure. All dental prostheses are excluded, except for those specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

49. Orthopedic shoes. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes, or regular shoes later built up.

50. Eyeglasses. Eyeglasses, spectacles, contact lenses, or other optical devices, except as specifically provided under subsection E.6. of this chapter.

51. Hearing aids. Hearing aids or other auditory sensory enhancing devices.

52. Telephonic services. Services or advice rendered by telephone or other telephonic device, including remote monitoring, except for transtelephonic monitoring of cardiac pacemakers.

53. Air conditioners, humidifiers, dehumidifiers, and purifiers.

54. Elevators or chair lifts.

55. Alterations. Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.

56. Clothing. Items of clothing or shoes, even if required by virtue of an allergy (such as cotton fabric as against synthetic fabric and vegetable dyed shoes).

57. Food, food substitutes. Food, food substitutes, vitamins, or other nutritional supplements, including those related to prenatal care.

June 24, 1994
DoD 6010.8-R

RESERVED

CHAPTER 5
PROGRAM FOR THE HANDICAPPED (PPTH)

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CHAPTER 5
PROGRAM FOR THE HANDICAPPED (PFTH)

A. GENERAL

The PFTH is essentially a program of financial assistance for military personnel on active duty whose spouses or children may be moderately or severely mentally retarded or seriously physically handicapped and in need of specialized institutional care, training, or rehabilitation, and the required services are not available from public institutions or agencies. The PFTH was established by Congress to be a source of financial assistance when an active duty member's handicapped dependents, by virtue of residency laws, have been excluded from appropriate publicly operated programs or institutions for the handicapped. There is, therefore, a requirement that all local resources must be considered and those determined as adequate be utilized first, before an application for coverage under the PFTH will be acted on by the Director, OCHAMPUS, or a designee. There is a further requirement that all institutional care otherwise authorized be provided in not-for-profit CHAMPUS-approved institutions. Coverage for any services or supplies under the PFTH requires prior approval.

1. Physical or mental examinations. The Director, OCHAMPUS, or a designee, may request a beneficiary to submit to one or more appropriate medical (including psychiatric) examinations to determine the beneficiary's entitlement to benefits for which application has been made or for otherwise authorized services and supplies required in the proposed management plan for the handicapped dependent. When such an examination has been requested, CHAMPUS will withhold payment of any pending claim or claims or preauthorization requests on that particular beneficiary. If the beneficiary or sponsor does not agree to the requested examination, or unless prevented by a medical reason acceptable to CHAMPUS, the examination is not performed within 90 days of the initial request, all pending claim or claims for services and supplies will be denied. A denial of payments for such services or supplies provided before and related to the request for a physical examination is not subject to reconsideration. The cost of the examination or examinations will be at the expense of CHAMPUS (including any related beneficiary transportation costs). The examination or examinations may be performed by a physician or physicians in a Uniformed Services medical facility or by an appropriate civilian physician, as determined and selected by the Director, OCHAMPUS, or a designee, who is responsible for making such arrangements as are necessary.

2. Right to information. As a condition precedent to the provision of benefits hereunder, OCHAMPUS or CHAMPUS fiscal intermediaries shall be entitled to receive information from a physician or hospital or other person, institution, or organization (including a local, state, or Federal Government agency) providing services or supplies to the beneficiary for which claims or requests for approval for benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, examination, diagnosis of, treatment rendered, or services and supplies furnished to, a beneficiary and shall be necessary for the accurate and efficient administration of CHAMPUS benefits. In addition, before a determination on a request for preauthorization or claim of benefits is made, a beneficiary or sponsor must provide particular additional information relevant to the requested determination, when necessary. The recipient of such information shall in every case hold such records confidential except when (a) disclosure of such information is authorized specifically by the beneficiary;

(h) disclosure is necessary to permit authorized governmental officials to investigate and prosecute criminal actions; or (c) disclosure is authorized or required specifically under the terms of the Privacy or Freedom of Information Acts (references (i), (j), and (k)) (refer to section M. of Chapter 1 of this Regulation). For the purposes of determining the applicability of and implementing the provisions of chapters 8, 11 and 12, or any provision of similar purpose of any other medical benefits coverage or entitlement, OCHAMPUS or CHAMPUS fiscal intermediaries, without consent or notice to any beneficiary or sponsor, may release to any insurance company or other organization, government agency, provider, or other entity any information with respect to any beneficiary when such release constitutes a routine use duly published in the Federal Register in accordance with the Privacy Act (reference (k)). Before a beneficiary's or sponsor's claim of benefits will be adjudicated, the beneficiary or sponsor must furnish to CHAMPUS that information which reasonably may be expected to be in his or her possession and that is necessary to make the benefit determination. Failure to provide the requested information may result in denial of the claim.

3. Claims filing deadline. For all services provided on or after January 1, 1993, to be considered for benefits, all claims submitted for benefits must, except as provided in Chapter 7, of this regulation, be filed with the appropriate CHAMPUS contractor no later than one year after the services are provided. Unless the requirement is waived, failure to file a claim within this deadline waives all rights to benefits for such services or supplies.

4. Eligibility for benefits

a. Eligibility criteria. Eligibility criteria for CHAMPUS generally are contained in Chapter 3 of this Regulation. However, coverage under the PFTH includes and is further limited to:

(1) The dependents, as defined in Chapter 3 but excluding former spouses, of a member of one of the Uniformed Services who is under call or order to active duty that does not specify a period of 30 days or less, who are moderately or severely mentally retarded or who have a serious physical handicap; or

(2) The dependents of a deceased active duty service member who died after January 1, 1967, while eligible for receipt of hostile fire pay or from a disease or injury incurred while eligible for such pay, who are under 21 years of age, and who otherwise meet the criteria of subparagraph A.4.a.(1), above, and were receiving benefits under the PFTH at the time of said member's death.

b. Sponsor ceases to be active duty member. When the sponsor ceases to be an active duty member because of death, benefits under the PFTH may be continued through the last day of the calendar month following the month in which the sponsor's death occurred. When the sponsor ceases to be an active duty member for any other reason, such as retirement, separation, or deserter status, benefits under the PFTH cease as of 12:01 a.m. of the day following the day the status of the sponsor changes. Exception is made only for those spouses and children under 21 years of age of deceased members

CHAPTER 6
AUTHORIZED PROVIDERS

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6. Exclusion of beneficiary liability. In connection with certain utilization review, quality assurance and preauthorization requirements of Chapter 4, providers may not hold patients liable for payment for certain services for which CHAMPUS payment is disallowed. With respect to such services, providers may not seek payment from the patient or the patient's family. Any such effort to seek payment is a basis for termination of the provider's authorized status.

7. Provider required. In order to be considered for benefits, all services and supplies shall be rendered by, prescribed by, or furnished at the direction of, or on the order of a CHAMPUS-authorized provider practicing within the scope of his or her license.

8. Participating providers.

a. In general. A Participating Provider is an individual or institutional provider that has agreed to accept the CHAMPUS-determined allowable amount as payment in full for the medical services and supplies provided to the CHAMPUS beneficiary, and has agreed to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing and deductible amounts paid by, or on behalf of, the beneficiary as full payment for the covered medical services or supplies. In addition, Participating Providers submit the appropriate claims forms to the appropriate CHAMPUS contractor on behalf of the beneficiary. There are several circumstances under which providers are Participating Providers.

b. Mandatory participation Medicare-participating hospitals are required by law to be Participating Providers on all inpatient claims under CHAMPUS. Hospitals that are not Medicare-participating providers but are subject to the CHAMPUS DRG-based payment system or the CHAMPUS mental health payment system (see Chapter 14.A.), must sign agreements to participate on all CHAMPUS inpatient claims in order to be authorized providers under CHAMPUS.

c. Participating Provider Program.

(1) In general. An institutional provider not required to participate pursuant to paragraph A.8.b, of this chapter and any individual provider may become a Participating Provider by signing a Participating Provider agreement. In such an agreement, the provider agrees that all CHAMPUS claims filed during the time period covered by the agreement will be on a participating basis.

(2) Agreement required. Under the Participating Provider Program, the provider must sign an agreement or memorandum of understanding under which the provider agrees to become a Participating Provider. Such an agreement may be with the nearby military treatment facility, a CHAMPUS contractor, or other authorized official. Such an agreement may include other provisions pertaining to the Participating Provider Program. The Director, OCHAMPUS shall establish a standard model agreement and other procedures to promote uniformity in the administration of the Participating Provider Program.

(3) Relationship to other activities. Participating Provider agreements may include other provisions, such as provisions regarding discounts (see Chapter 14.1) or other provisions in connection with the delivery and financing of health care services, as authorized by this chapter or other DoD Directives or Instructions. Participating Provider agreement provisions may also be incorporated into other types of agreements, such as preferred provider arrangements where

such arrangements are established under CHAMPUS.

d. Claim-by-claim-participation. Institutional and individual providers that are not participating providers pursuant to paragraphs A.8.b., or c., of this chapter, may elect to participate on a claim-by-claim basis. They may do so by signing the appropriate space on the claims form and submitting it to the appropriate CHAMPUS contractor on behalf of the beneficiary.

9. Limitation to authorized institutional provider designation. Authorized institutional provider status granted to a specific institutional provider applicant does not extend to any institution-affiliated provider, as defined in Chapter 2 of this Regulation, of that specific applicant.

10. Authorized provider. A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized in this chapter to provide benefits under CHAMPUS. In addition, to be an authorized CHAMPUS provider, any hospital which is a CHAMPUS participating provider under Section A.7. of this chapter, shall be a participating provider for all care, services, or supplies furnished to an active duty member of the uniformed services for which the active duty member is entitled under title 10, United States Code, section 1074(c). As a participating provider for active duty members, the CHAMPUS authorized hospital shall provide such care, services, and supplies in accordance with the payment rules of Chapter 16. The failure of any CHAMPUS participating hospital to be a participating provider for any active duty member subjects the hospital to termination of the hospital's status as a CHAMPUS authorized provider for failure to meet the qualifications established by this chapter.

11. Submittal of claims by provider required.

a. General rule. Unless waived pursuant to paragraph A.11.b., of this chapter, every CHAMPUS-authorized institutional and individual provider is required to submit CHAMPUS claims to the appropriate CHAMPUS contractor on behalf of the beneficiary for all services and supplies. In addition, the provider may not impose any charge relating to completing and submitting the applicable claim form (or any other related information). (Although CHAMPUS encourages provider participation, this paragraph A.11., requires only the submission of claim forms by providers on behalf of beneficiaries; it does not require that providers accept assignment of beneficiaries' claims or become participating providers.)

b. Waiver of claims submission requirement. The requirement that providers submit claims on behalf of beneficiaries may be waived in circumstances set forth in this paragraph A.11.b. A decision by the Director, OCHAMPUS to waive or not to waive the requirement in any particular circumstance is not subject to the appeal and hearing procedures of Chapter 10 of this regulation.

(1) General requirement for waiver. The requirement that providers submit claims on behalf of beneficiaries may be waived by the Director, OCHAMPUS when the Director determines that the waiver is necessary in order to ensure adequate access for CHAMPUS beneficiaries to health care services. However, the requirement may not be waived for Participating Providers (see paragraph A.8., of this chapter).

(2) Blanket waiver for provider outside the United States. The requirement

that providers submit claims is waived with respect to providers outside the United States (the United States includes Puerto Rico for this purpose).

(3) Blanket waiver in double coverage cases. The requirement that providers submit claims is waived in cases in which another insurance plan or program provides primary coverage for the services.

(4) Waivers for particular categories of care. The Director, OCHAMPUS may waive the requirement that providers submit claims if the Director determines that available evidence clearly shows that the requirement would impair adequate access. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the number of such providers who are CHAMPUS Participating Providers, the number of CHAMPUS beneficiaries in the area, and other relevant factors. Providers or beneficiaries in a locality may submit to the Director, OCHAMPUS a petition, together with appropriate documentation regarding relevant factors, for a determination that adequate access would be impaired. The Director, OCHAMPUS will consider and respond to all such petitions. The Director, OCHAMPUS may establish procedures for handling such petitions.

(5) Case-by-case waivers. On a case-by-case basis, the Director, OCHAMPUS may waive the provider's obligation to submit that claim if the Director determines that a waiver in that case is necessary in order to ensure adequate access for CHAMPUS beneficiaries to the health care services involved. Such case-by-case waivers may be requested by providers or beneficiaries pursuant to procedures established by the Director.

c. Remedies for noncompliance.

(1) In any case in which a provider fails to submit a claim, or charges an administrative fee for filing a claim (or any other related information), in violation of the requirements of this paragraph A.11., the amount that would otherwise be allowable for the claim shall be reduced by ten percent, unless the reduction is waived by the Director, OCHAMPUS based on special circumstances. The amount disallowed by such a reduction may not be billed to the patient (or the patient's sponsor or family).

(2) Repeated failures by a provider to comply with the requirements of this paragraph A.11., shall be considered abuse and/or fraud and grounds for exclusion or suspension of the provider under Chapter 9., of this regulation.

12. Balance billing limits.

a. In general. Individual providers who are not participation providers may not balance bill a beneficiary an amount which exceeds the applicable billing limit. The balance billing limit shall be the same percentage as the Medicare limiting charge percentage for nonparticipating physicians.

b. Waiver. The balance billing limit may be waived by the Director, OCHAMPUS on a case-by-case basis if requested by a CHAMPUS beneficiary. A decision by the Director, OCHAMPUS to waive or not to waive the limit in any particular case is not subject to the appeal and hearing procedures in Chapter 10., of this regulation.

c. Compliance. Failure to comply with the balance billing limit shall be considered abuse and/or fraud and grounds for exclusion or suspension of the provider under Chapter 9., of this regulation.

B. INSTITUTIONAL PROVIDERS

1. General. Institutional providers are those providers who bill for services in the name of an organizational entity (such as hospital and skilled nursing facility), rather than in the name of a person. The term "institutional provider" does not include professional corporations or associations qualifying as a domestic corporation under section 301.7701-5 of the Internal Revenue Service Regulations (reference (cc)), nor does it include other corporations that provide principally professional services. Institutional providers may provide medical services and supplies on either an inpatient or outpatient basis.

a. Preauthorization. Preauthorization may be required by the Director, OCHAMPUS for any health care service for which payment is sought under CHAMPUS. (See Chapters 4 and 15 for further information on preauthorization requirements.)

b. Billing practices.

(1) Each institutional billing, including those institutions subject to the CHAMPUS DRG-based reimbursement method or a CHAMPUS-determined all-inclusive rate reimbursement method, must be itemized fully and sufficiently descriptive for the CHAMPUS to make a determination of benefits.

(2) Institutional claims subject to the CHAMPUS DRG-based reimbursement method or a CHAMPUS-determined all-inclusive rate reimbursement method, may be submitted only after the beneficiary has been discharged or transferred from the institutional provider's facility or program.

(3) Institutional claims for Residential Treatment Centers and all other institutional providers, except those listed in subparagraph (2) above, should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days.

c. Medical records. Institutional providers must provide adequate contemporaneous clinical records to substantiate that specific care was actually furnished, was medically necessary, and appropriate, and to identify the individual(s) who provided the care. The minimum requirements for medical record documentation are set forth by the following:

(1) The cognizant state licensing authority;

(2) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or other health care accreditation organizations as may be appropriate;

(i) Professional staff. The center's professional staff is legally and professionally qualified for the performance of their professional responsibilities.

(j) Medical records. The center maintains full and complete written documentation of the services rendered to each woman admitted and each newborn delivered. A copy of the informed consent document required by subparagraph (c), above, which contains the original signature of the CHAMPUS beneficiary, signed and dated at the time of admission, must be maintained in the medical record of each CHAMPUS beneficiary admitted.

(k) Quality assurance. The center has an organized program for quality assurance which includes, but is not limited to, written procedures for regularly scheduled evaluation of each type of service provided, of each mother or newborn transferred to a hospital, and of each death within the facility.

(l) Governance and administration. The center has a governing body legally responsible for overall operation and maintenance of the center and a full-time employee who has authority and responsibility for the day-to-day operation of the center.

1. Psychiatric partial hospitalization programs. Psychiatric partial hospitalization programs must be either a distinct part of an otherwise authorized institutional provider or a freestanding program. The treatment program must be under the general direction of a psychiatrist employed by the partial hospitalization program to ensure medication and physical needs of all the patients are considered. The primary or attending provider must be a CHAMPUS authorized mental health provider, operating within the scope of his/her license. These categories include physicians, clinical psychologists, certified psychiatric nurse specialists, clinical social workers, marriage and family counselors, pastoral counselors and mental health counselors. CHAMPUS reimbursement is limited to programs complying with all requirements of Chapter 4, paragraph B.10. In addition, in order for a partial hospitalization program (PHP) to be authorized, the PHP shall comply with the following requirements:

(1) The PHP shall comply with the CHAMPUS Standards for Partial Hospitalization Programs and Facilities, as promulgated by the Director, OCHAMPUS.

(2) The PHP shall be specifically accredited by and remain in substantial compliance with standards issued by the Joint Commission on Accreditation of Healthcare Organizations under the Mental Health Manual (formerly the Consolidated Standards). NOTE: A one-time grace period is being allowed not to exceed October 1, 1994 for this provision only if the provider is already accredited under the JCAHO hospital standards. The provider must agree not to accept any new admissions for CHAMPUS patients for care beyond October 1, 1994, if accreditation and substantial compliance with the Mental Health Manual standards have not been obtained by that date.

(3) The PHP shall be licensed as a partial hospitalization program to provide PHP services within the applicable jurisdiction in which it operates.

(4) The PHP shall accept the CHAMPUS-allowable partial hospitalization program rate, as provided in Chapter 14, paragraph A.2.i., as payment in full for services provided.

(5) The PHP shall comply with all requirements of this section applicable to institutional providers generally concerning preauthorization, concurrent care review, claims processing, beneficiary liability, double coverage, utilization and quality review and other matters.

(6) The PHP must be fully operational and treating patients for a period of at least six months (with at least 30 percent minimum patient census) before an application for approval may be submitted. The PHP shall not be considered a CHAMPUS-authorized provider nor may any CHAMPUS benefits be paid to the facility for any services provided prior to the date the facility is approved by the Director, OCHAMPUS, or designee.

(7) All mental health services must be provided by a CHAMPUS-authorized mental health provider. [Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate but the individual must work under the clinical supervision of a fully qualified mental health provider employed by the PHP.] All other program services shall be provided by trained, licensed staff.

(8) The PHP shall ensure the provision of an active family therapy treatment component which assures that each patient and family participate at least weekly in family therapy provided by the institution and rendered by a CHAMPUS authorized mental health provider.

(9) The PHP must have a written agreement with at least one backup CHAMPUS-authorized hospital which specifies that the hospital will accept any and all CHAMPUS beneficiaries transferred for emergency mental health or medical/surgical care. The PHP must have a written emergency transport agreement with at least one ambulance company which specifies the estimated transport time to each backup hospital.

(10) The PHP shall enter into a participation agreement with the Director, OCHAMPUS, which shall include but which shall not be limited to the following provisions:

(a) The PHP agrees not to bill the beneficiary for services in excess of the cost-share or services for which payment is disallowed for failure to comply with requirements for preauthorization or concurrent care review.

(b) The PHP agrees not to bill the beneficiary for services excluded on the basis of Chapter 4, paragraphs G.1. (not medically necessary), G.3. (inappropriate level of care) or G.7. (custodial care), unless the beneficiary has agreed in writing to pay for the care, knowing the specific care in question had been determined noncovered by CHAMPUS. (A general statement signed at admission as to financial liability does not fulfill this requirement.)

C. INDIVIDUAL PROFESSIONAL PROVIDERS OF CARE

1. General. Individual professional providers of care are those providers who bill for their services on a fee-for-service basis and are not employed or

under a contract which provides for payment to the individual professional provider by an institutional provider. This category also includes those individuals who have formed professional corporations or associations qualifying as a domestic corporation under section 301.7701-5 of the Internal Revenue Service Regulations (reference (cc)). Such individual professional providers must be licensed or certified by the local licensing or certifying agency for the jurisdiction in which the care is provided; or in the absence of state licensure/certification, be a member of or demonstrate eligibility for full clinical membership in, the appropriate national or professional certifying association that sets standards for the profession of which the provider is a member. Services provided must be in accordance with good medical practice and prevailing standards of quality of care and within recognized utilization norms.

a. Licensing/Certification required, scope of license. Otherwise covered services shall be cost-shared only if the individual professional provider holds a current, valid license or certification to practice his or her profession in the jurisdiction where the service is rendered. Licensure/certification must be at the full clinical practice level. The services provided must be within the scope of the license, certification or other legal authorization. Licensure or certification is required to be a CHAMPUS authorized provider if offered in the jurisdiction where the service is rendered, whether such licensure or certification is required by law or provided on a voluntary basis. The requirement also applies for those categories of providers that would otherwise be exempt by the state because the provider is working in a non-profit, state-owned or church setting. Licensure/certification is mandatory for a provider to become a CHAMPUS-authorized provider.

b. Monitoring required. The Director, OCHAMPUS, or a designee, shall develop appropriate monitoring programs and issue guidelines, criteria, or norms necessary to ensure that CHAMPUS expenditures are limited to necessary medical supplies and services at the most reasonable cost to the government and beneficiary. The Director, OCHAMPUS, or a designee, also will take such steps as necessary to deter overutilization of services.

c. Christian Science. Christian Science practitioners and Christian Science nurses are authorized to provide services under CHAMPUS. Inasmuch as they provide services of an extramedical nature, the general criteria outlined above do not apply to Christian Science services (refer to subparagraph C.3.d.(2), below, regarding services of Christian Science practitioners and nurses).

d. Physician referral and supervision. Physician referral and supervision is required for the services of paramedical providers as listed in subparagraph C.3.c.8. and for pastoral counselors, and mental health counselors. Physician referral means that the physician must actually see the patient, perform an evaluation, and arrive at an initial diagnostic impression prior to referring the patient. Documentation is required of the physician's examination, diagnostic impression, and referral. Physician supervision means that the physician provides overall medical management of the case. The physician does not have to be physically located on the premises of the provider to whom the referral is made. Communication back to the referring physician is an indication of medical management.

e. Medical records: Individual professional providers must maintain adequate clinical records to substantiate that specific care was actually furnished, was medically necessary, and appropriate, and identify(ies) the individual(s) who provided the care. This applies whether the care is inpatient or outpatient. The minimum requirements for medical record documentation are set forth by the following:

- (1) The cognizant state licensing authority;
- (2) The Joint Commission on Accreditation of Healthcare Organizations, or other health care accreditation organizations as may be appropriate;
- (3) Standards of practice established by national medical organizations; and
- (4) This Regulation.

2. Interns and residents. Interns and residents may not be paid directly by CHAMPUS for services rendered to a beneficiary when their services are provided as part of their employment (either salaried or contractual) by a hospital or other institutional provider.

(c) Has had a minimum of 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting, as determined by the Director, OCHAMPUS, or a designee.

NOTE: Patients' organic medical problems must receive appropriate concurrent management by a physician.

(7) Certified psychiatric nurse specialist. A certified psychiatric nurse specialist may provide covered care independent of physician referral and supervision. For purposes of CHAMPUS, a certified psychiatric nurse specialist is an individual who:

(a) Is a licensed, registered nurse; and

(b) Has at least a master's degree in nursing from a regionally accredited institution with a specialization in psychiatric and mental health nursing; and

(c) Has had at least 2 years of post-master's degree practice in the field of psychiatric and mental health nursing, including an average of 8 hours of direct patient contact per week; or

(d) Is listed in a CHAMPUS-recognized, professionally sanctioned listing of clinical specialists in psychiatric and mental health nursing.

(8) Certified physician assistant. A physician assistant may provide care under general supervision of a physician (see Chapter 14 G.I.c. for limitations on reimbursement). For purposes of CHAMPUS, a physician assistant must meet the applicable state requirements governing the qualifications of physician assistants and at least one of the following conditions:

(a) Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians, or

(b) Has satisfactorily completed a program for preparing physician assistants that:

1 Was at least 1 academic year in length;

2 Consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and

3 Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or

(c) Has satisfactorily completed a formal educational program for preparing physician assistants that does not meet the requirements of subparagraph (1)(b) of this paragraph and had been assisting primary care physicians for a minimum of 12 months during the 18-month period immediately preceding January 1, 1987.

(9) Other individual paramedical providers. The services of the following individual professional providers of care to be considered for benefits on a fee-for-service basis may be provided only if the beneficiary is referred by a physician for the treatment of a medically-diagnosed condition and a physician must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by these individual paramedical providers.

- (a) Licensed registered nurses.
- (b) Licensed practical or vocational nurses.
- (c) Licensed registered physical therapists.
- (d) Audiologists.
- (e) Speech therapists (speech pathologists).

d. Extramedical individual providers. Extramedical individual providers are those who do counseling or nonmedical therapy and whose training and therapeutic concepts are outside the medical field. The services of extramedical individual professionals are coverable following the CHAMPUS determined allowable charge methodology provided such services are otherwise authorized in this or other chapters of the regulation.

(1) Certified marriage and family therapists. For the purposes of CHAMPUS, a certified marriage and family therapist is an individual who meets the following requirements:

(a) Recognized graduate professional education with the minimum of an earned master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline; and

(b) The following experience:

1 Either 200 hours of approved supervision in the practice of marriage and family counseling, ordinarily to be completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases; and

2 1,000 hours of clinical experience in the practice of marriage and family counseling under approved supervision, involving at least 50 different cases; or

3 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years; and

4 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in marriage and family counseling under approved supervision, involving at least 20 cases; and

(c) Is licensed or certified to practice as a marriage and family therapist by the jurisdiction where practicing (see C.3.d.(4) of this part for more specific information regarding licensure); and

(d) Agrees that a patients' organic medical problems must receive appropriate concurrent management by a physician.

(e) Agrees to accept the CHAMPUS determined allowable charge as payment in full, except for applicable deductibles and cost-shares, and hold CHAMPUS beneficiaries harmless for noncovered care (i.e., may not bill a beneficiary for noncovered care, and may not balance bill a beneficiary for amounts above the allowable charge). The certified marriage and family therapist must enter into a participation agreement with the Office of CHAMPUS within which the certified marriage and family therapist agrees to all provisions specified above.

(f) As of the effective date of termination, the certified marriage and family therapist, will no longer be recognized as an authorized provider under CHAMPUS. Subsequent to termination, the certified marriage and family therapist may only be reinstated as an authorized CHAMPUS extramedical provider by entering into a new participation agreement as a certified marriage and family therapist.

(2) Pastoral counselors. For the purposes of CHAMPUS a pastoral counselor is an individual who meets the following requirements:

(a) Recognized graduate professional education with the minimum of an earned master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline; and

(b) The following experience:

1 Either 200 hours of approved supervision in the practice of pastoral counseling, ordinarily to be completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases; and

2 1,000 hours of clinical experience in the practice of pastoral counseling under approved supervision, involving at least 50 different cases; or

3 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of pastoral counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years; and

4 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in pastoral counseling under approved supervision, involving at least 20 cases; and

(c) Is licensed or certified to practice by the jurisdiction where practicing (see C.3.d.(4) of this part for more specific information regarding licensure); and

(d) The services of a pastoral counselor meeting the above requirements are coverable following the CHAMPUS determined allowable charge methodology, under the following specified conditions:

1 The CHAMPUS beneficiary must be referred for therapy by a physician; and

2 A physician is providing ongoing oversight and supervision of the therapy being provided; and

3 The pastoral counselor must certify on each claim for reimbursement that a written communication has been made or will be made to the referring physician of the results of the treatment. Such communication will be made at the end of the treatment, or more frequently, as required by the referring physician (refer to Chapter 7).

(e) Because of the similarity of the requirements for licensure, certification, experience and education a pastoral counselor may elect to be authorized under CHAMPUS as a certified marriage and family therapist, and as such, be subject to all previously defined criteria for the certified marriage and family therapist category, to include acceptance of the CHAMPUS determined allowable charge as payment in full, except for applicable deductibles and cost-shares, (i.e., balance billing of a beneficiary above the allowable charge is prohibited; may not bill beneficiary for noncovered care). The pastoral counselor must also agree to enter into the same participation agreement as a certified marriage and family therapist with the Office of CHAMPUS within which the pastoral counselor agrees to all provisions, including licensure, national association membership and conditions upon termination, outlined above for certified marriage and family therapists.

NOTE: No dual status will be recognized by the Office of CHAMPUS. Pastoral counselors must elect to become one of the categories of extramedical CHAMPUS providers specified above. Once authorized as either a pastoral counselor,

or a certified marriage and family therapist, claims review and reimbursement will be in accordance with the criteria established for the elected provider category.

(3) Mental Health Counselor. For the purposes of CHAMPUS, a mental health counselor is an individual who meets the following requirements:

(a) Minimum of a master's degree in mental health counseling or allied mental health field from a regionally accredited institution; and

(b) Two years of post-master's experience which includes 3000 hours of clinical work and 100 hours of face-to-face supervision; and

(c) Is licensed or certified to practice as a mental health counselor by the jurisdiction where practicing (see C.3.d.(4) of this part for more specific information); and

(d) May only be reimbursed when:

1 The CHAMPUS beneficiary is referred for therapy by a physician; and

2 A physician is providing ongoing oversight and supervision of the therapy being provided; and

3 The mental health counselor certifies on each claim for reimbursement that a written communication has been made or will be made to the referring physician of the results of the treatment. Such communication will be made at the end of the treatment, or more frequently, as required by the referring physician (refer to Chapter 7).

(4) The following additional information applies to each of the above categories of extramedical individual providers:

(a) These providers must also be licensed or certified to practice as a certified marriage and family therapist, pastoral counselor or mental health counselor by the jurisdiction where practicing. In jurisdictions that do not provide for licensure or certification, the provider must be certified by or eligible for full clinical membership in the appropriate national professional association that sets standards for the specific profession.

(b) Grace period for therapists or counselors in states where licensure/certification is optional. CHAMPUS is providing a grace period for those therapists or counselors who did not obtain optional licensure/certification in their jurisdiction, not realizing it was a CHAMPUS requirement for authorization. The exemption by state law for pastoral counselors may have misled this group into thinking licensure was not required. The same situation may have occurred with the other therapist or counselor categories. This grace period pertains only to the licensure/certification requirement, applies only to therapists or counselors who

are already approved as of October 29, 1990, and only in those areas where the licensure/certification is optional. Any therapist or counselor who is not licensed/certified in the state in which he/she is practicing by August 1, 1991, will be terminated under the provisions of Section 199.9 of this part. This grace period does not change any of the other existing requirements which remain in effect. During this grace period, membership or proof of eligibility for full clinical membership in a recognized professional association is required for those therapists or counselors who are not licensed or certified by the state. The following organizations are recognized for therapists or counselors at the level indicated: full clinical member of the American Association of Marriage and Family Therapy; membership at the fellow or diplomate level of the American Association of Pastoral Counselors; and membership in the National Academy of Certified Clinical Mental Health Counselors. Acceptable proof of eligibility for membership is a letter from the appropriate certifying organization. This opportunity for delayed certification/licensure is limited to the counselor or therapist category only as the language in all of the other provider categories has been consistent and unmodified from the time each of the other provider categories were added. The grace period does not apply in those states where licensure is mandatory.

(5) Christian Science practitioners and Christian Science nurses. CHAMPUS cost shares the services of Christian Science practitioners and nurses. In order to bill as such, practitioners or nurses must be listed or be eligible for listing in the Christian Science Journal at the time the service is provided.

D. OTHER PROVIDERS

Certain medical supplies and services of an ancillary or supplemental nature are coverable by CHAMPUS, subject to certain controls. This category of provider includes the following:

1. Independent laboratory. Laboratory services of independent laboratories may be cost-shared if the laboratory is approved for participation under Medicare and certified by the Medicare Bureau, Health Care Financing Administration.

2. Suppliers of portable x-ray services. Such suppliers must meet the conditions of coverage of the Medicare program, set forth in the Medicare regulations (reference (h)), or the Medicaid program in that state in which the covered service is provided.

3. Pharmacies. Pharmacies must meet the applicable requirements of state law in the state in which the pharmacy is located.

4. Ambulance companies. Such companies must meet the requirements of state and local laws in the jurisdiction in which the ambulance firm is licensed.

5. Medical equipment firms, medical supply firms. As determined by the Director, OCHAMPUS, or a designee.

6. Mammography Suppliers. Mammography services may be cost-shared only if the supplier is certified by Medicare for participation as a mammography supplier, or is certified by the American College of Radiology as having met its mammography supplier standards.

E. IMPLEMENTING INSTRUCTIONS

The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this chapter.

F. EXCLUSION

Regardless of any provision in this chapter, a provider who is suspended, excluded, or terminated under Chapter 9 of this Regulation is specifically excluded as an authorized CHAMPUS provider.

CHAPTER 7
CLAIMS SUBMISSION, REVIEW, AND PAYMENT

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b. Physician or other authorized individual professional provider. A physician or other authorized individual professional provider is liable for any signature submitted on his or her behalf. Further, a facsimile signature is not acceptable unless such facsimile signature is on file with, and has been authorized specifically by, the CHAMPUS fiscal intermediary serving the state where the physician or other authorized individual professional provider practices.

c. Hospital or other authorized institutional provider. The provider signature on a claim form for institutional services must be that of an authorized representative of the hospital or other authorized institutional provider, whose signature is on file with and approved by the appropriate CHAMPUS fiscal intermediary.

D. Claims filing deadline. For all services provided on or after January 1, 1993, to be considered for benefits, all claims submitted for benefits must, except as provided in paragraph D.2., of this Chapter, be filed with the appropriate CHAMPUS contractor no later than one year after the services are provided. Unless the requirement is waived, failure to file a claim within this deadline waives all rights to benefits for such services or supplies.

1. Claims returned for additional information. When a claim is submitted initially within the claim filing time limit, but is returned in whole or in part for additional information to be considered for benefits, the returned claim, along with the requested information must be resubmitted and received by the appropriate CHAMPUS contractor no later than the later of: (1) one year after the services are provided; or (2) 90 days from the date the claim was returned to the provider or beneficiary.

2. Exception to claims filing deadline. The Director, OCHAMPUS, or a designee, may grant exceptions to the claims filing deadline requirements.

a. Types of exception

(1) Retroactive eligibility. Retroactive CHAMPUS eligibility determinations.

(2) Administrative error. Administrative error (that is, misrepresentation, mistake, or other accountable action) of an officer or employee of OCHAMPUS (including OCHAMPUSEUR) or a CHAMPUS fiscal intermediary, performing functions under CHAMPUS and acting within the scope of that official's authority.

(3) Mental incompetency. Mental incompetency of the beneficiary or guardian or sponsor, in the case of a minor child (which includes inability to communicate, even if it is the result of a physical disability).

(4) Provider billings. Direct billings by participating providers.

(5) Delays by other health insurance. When not attributable to the beneficiary, delays in adjudication by other health insurance companies when double coverage coordination is required before the CHAMPUS benefit determination.

b. Request for exception to claims filing deadline. Beneficiaries who wish to request an exception to the claims filing deadline may submit such a request to the CHAMPUS fiscal intermediary having jurisdiction over the location in which the service was rendered, or as otherwise designated by the Director, OCHAMPUS.

(1) Such requests for an exception must include a complete explanation of the circumstances of the late filing, together with all available documentation supporting the request, and the specific claim denied for late filing.

(2) Each request for an exception to the claims filing deadline is reviewed individually and considered on its own merits.

E. Other waiver authority. The Director, OCHAMPUS may waive the claims filing deadline in other circumstances in which the Director determines that the waiver is necessary in order to ensure adequate access for CHAMPUS beneficiaries to health care services.

1. Continuing care. Except for claims subject to the CHAMPUS DRG-based payment system, whenever medical services and supplies are being rendered on a continuing basis, an appropriate claim or claims should be submitted every 30 days (monthly) whether submitted directly by the beneficiary or sponsor or by the provider on behalf of the beneficiary. Such claims may be submitted more frequently if the beneficiary or provider so elects. The Director, OCHAMPUS, or a designee, also may require more frequent claims submission based on dollars. Examples of care that may be rendered on a continuing basis are outpatient physical therapy, private duty (special) nursing, or inpatient stays. For claims subject to the CHAMPUS DRG-based payment system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

2. Inpatient mental health services. Under most circumstances, the 60-day inpatient mental health limit applies to the first 60 days of care paid in a calendar year. The patient will be notified when the first 30 days of inpatient mental health benefits have been paid. The beneficiary is responsible for assuring that all claims for care are submitted sequentially and on a regular basis. Once payment has been made for care determined to be medically appropriate and a program benefit, the decision will not be reopened solely on the basis that previous inpatient mental health care had been rendered but not yet billed during the same calendar year by a different provider.

3. Claims involving the services of marriage and family counselors, pastoral counselors, and mental health counselors. CHAMPUS requires that certified marriage and family therapists, pastoral counselors, and mental health counselors make a written report to the referring physician concerning the CHAMPUS beneficiary's progress. Therefore, each claim for reimbursement for services of marriage and family counselors, pastoral counselors, and mental health counselors must include certification to the effect that a written communication has been made or will be made to the referring physician at the end of treatment, or more frequently, as required by the referring physician.

F. PREAUTHORIZATION

When specifically required in other chapters of this Regulation, preauthorization requires the following:

1. Preauthorization must be granted before benefits can be extended. In those situations requiring preauthorization, the request for such preauthorization shall be submitted and approved before benefits may be extended, except as provided in Chapter 4, subsection A.11. If a claim for services or supplies is submitted without the required preauthorization, no benefits shall be paid, unless the Director, OCHAMPUS, or a designee, has granted an exception to the requirement for preauthorization.

a. Specifically preauthorized services. An approved preauthorization specifies the exact services or supplies for which authorization is being given. In a preauthorization situation, benefits cannot be extended for services or supplies provided beyond the specific authorization.

b. Time limit on preauthorization. Approved preauthorizations are valid for specific periods of time, appropriate for the circumstances presented and specified at the time the preauthorization is approved. In general, preauthorizations are valid for 30 days. If the preauthorized service or supplies are not obtained or commenced within the specified time limit, a new preauthorization is required before benefits may be extended.

2. Treatment plan, management plan. Each preauthorization request shall be accompanied by a proposed medical treatment plan (for inpatient stays under the Basic Program) or management plan (for services under the PPTH) which shall include generally a diagnosis; a detailed summary of complete history and physical; a detailed statement of the problem; the proposed type and extent of treatment or therapy; the proposed treatment modality, including anticipated length of time the proposed modality will be required; any available test results; consultant's reports; and the prognosis. When the preauthorization request involves transfer from a hospital to another inpatient facility, medical records related to the inpatient stay also must be provided.

3. Durable equipment. Requests for preauthorization to purchase durable equipment under the PPTH must list all items of durable equipment previously authorized under the PPTH and state whether the current item of equipment is the initial purchase or a replacement. If it is a replacement item, the date the initial item was purchased also shall be provided.

4. Claims for services and supplies that have been preauthorized. Whenever a claim is submitted for benefits under CHAMPUS involving preauthorized services and supplies, the date of the approved preauthorization must be indicated on the claim form and a copy of the written preauthorization must be attached to the appropriate CHAMPUS claim.

G. CLAIMS REVIEW

It is the responsibility of the CHAMPUS fiscal intermediary (or OCHAMPUS, including OCHAMPUSEUR) to review each CHAMPUS claim submitted for benefit consideration to ensure compliance with all applicable definitions, conditions, limitations, or exclusions specified or enumerated in this Regulation. It is also required that before any CHAMPUS benefits may be extended, claims for medical services and supplies will be subject to utilization review and quality assurance standards, norms, and criteria issued by the Director, OCHAMPUS, or a designee (see paragraph A.1.e. of Chapter 14 for review standards for claims subject to the CHAMPUS DRG-based payment system).

H. BENEFIT PAYMENTS

CHAMPUS benefit payments are made either directly to the beneficiary or sponsor or to the provider, depending on the manner in which the CHAMPUS claim is submitted.

1. Benefit payments made to beneficiary or sponsor. When the CHAMPUS beneficiary or sponsor signs and submits a specific claim form directly to the appropriate CHAMPUS fiscal intermediary (or OCHAMPUS, including OCHAMPUSEUR), any CHAMPUS benefit payments due as a result of that specific claim submission will be made in the name of, and mailed to, the beneficiary or sponsor. In such circumstances, the beneficiary or sponsor is responsible to the provider for any amounts billed.

2. Benefit payments made to participating provider. When the authorized provider elects to participate by signing a CHAMPUS claim form, indicating participation in the appropriate space on the claim form, and submitting a specific claim on behalf of the beneficiary to the appropriate CHAMPUS fiscal intermediary, any CHAMPUS benefit payments due as a result of that claim submission will be made in the name of and mailed to the participating provider. Thus, by signing the claim form, the authorized provider agrees to abide by the CHAMPUS-determined allowable charge or cost, whether or not lower than the amount billed. Therefore, the beneficiary or sponsor is responsible only for any required deductible amount and any cost-sharing portion of the CHAMPUS-determined allowable charge or cost as may be required under the terms and conditions set forth in Chapters 4 and 5 of this Regulation.

3. CEOB. When a CHAMPUS claim is adjudicated, a CEOB is sent to the beneficiary or sponsor. A copy of the CEOB also is sent to the provider if the claim was submitted on a participating basis. The CEOB form provides, at a minimum, the following information:

CHAPTER 14

PROVIDER REIMBURSEMENT METHODS

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CHAPTER 14
PROVIDER REIMBURSEMENT METHODS

A. HOSPITALS

The CHAMPUS-determined allowable cost for reimbursement of a hospital shall be determined on the basis of one of the following methodologies.

1. CHAMPUS Diagnosis Related Group(DRG)-based payment system. Under the CHAMPUS DRG-based payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system is made on the basis of prospectively-determined rates and applied on a per discharge basis using DRGs. Payments under this system will include a differentiation for urban (using large urban and other urban areas) and rural hospitals and an adjustment for area wage differences and indirect medical education costs. Additional payments will be made for capital costs, direct medical education costs, and outlier cases.

a. General.

(1) DRGs used. The CHAMPUS DRG-based payment system will use the same DRGs used in the most recently available grouper for the Medicare Prospective Payment System, except as necessary to recognize distinct characteristics of CHAMPUS beneficiaries and as described in instructions issued by the Director, OCHAMPUS.

(2) Assignment of discharges to DRGs.

(a) The classification of a particular discharge shall be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed and discharge status. In addition, for neonatal cases (other than normal newborns) the classification shall also account for birthweight, surgery and the presence of multiple, major and other neonatal problems, and shall incorporate annual updates to these classification features.

(b) Each discharge shall be assigned to only one DRG regardless of the number of conditions treated or services furnished during the patient's stay.

(3) Basis of payment.

(a) Hospital billing. Under the CHAMPUS DRG-based payment system, hospitals are required to submit claims (including itemized charges) in accordance with Chapter 7, paragraph B. The CHAMPUS fiscal intermediary will assign the appropriate DRG to the claim based on the information contained on the claim. Any request from a hospital for reclassification of a claim to a higher weighted DRG must be submitted, within 60 days from the date of the initial payment, in a manner prescribed by the Director, OCHAMPUS.

(b) Payment on a per discharge basis. Under the CHAMPUS DRG-based payment system, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to CHAMPUS beneficiaries.

(c) Claims priced as of date of admission. Except for interim claims submitted for qualifying outlier cases, all claims reimbursed under the CHAMPUS DRG-based payment system are to be priced as of the date of admission, regardless of when the claim is submitted.

(d) Payment in full. The DRG-based amount paid for inpatient hospital services is the total CHAMPUS payment for the inpatient operating costs (as described in subparagraph A.1.a.(3)(e)) incurred in furnishing services covered by the CHAMPUS. The full prospective payment amount is payable for each stay during which there is at least one covered day of care, except as provided in subparagraph A.1.c.(5)(a)1a.

(e) Inpatient operating costs. The CHAMPUS DRG-based payment system provides a payment amount for inpatient operating costs, including:

1 Operating costs for routine services; such as the costs of room, board, and routine nursing services;

2 Operating costs for ancillary services, such as hospital radiology and laboratory services (other than physicians' services) furnished to hospital inpatients;

3 Special care unit operating costs; and

4 Malpractice insurance costs related to services furnished to inpatients.

(f) Discharges and transfers.

1 Discharges. A hospital inpatient is discharged when:

a The patient is formally released from the hospital (release of the patient to another hospital as described in subparagraph 2 of this subparagraph, or a leave of absence from the hospital, will not be recognized as a discharge for the purpose of determining payment under the CHAMPUS DRG-based payment system);

b The patient dies in the hospital; or

c The patient is transferred from the care of a hospital included under the CHAMPUS DRG-based payment system to a hospital or unit that is excluded from the prospective payment system.

2 Transfers. Except as provided under subparagraph A.1.a.(3)(f)1, a discharge of a hospital inpatient is not counted for purposes of the CHAMPUS DRG-based payment system when the patient is transferred:

a From one inpatient area or unit of the hospital to another area or unit of the same hospital;

or state as established by local or state regulatory authority, excluding title XIX of the Social Security Act or other welfare program, when extended to CHAMPUS beneficiaries by consent or agreement.

4. CHAMPUS discount rates. The CHAMPUS-determined allowable cost for authorized care in any hospital may be based on discount rates established under section I. of this chapter.

B. SKILLED NURSING FACILITIES (SNFs)

The CHAMPUS-determined allowable cost for reimbursement of a SNF shall be determined on the same basis as for hospitals which are not subject to the CHAMPUS DRG-based payment system.

C. REIMBURSEMENT FOR OTHER THAN HOSPITALS AND SNFs

The Director, OCHAMPUS, or a designee, shall establish such other methods of determining allowable cost or charge reimbursement for those institutions, other than hospitals and SNFs, as may be required.

D. Payment of Institutional facility costs for ambulatory surgery.

1. In general. CHAMPUS pays institutional facility costs for ambulatory surgery on the basis of prospectively determined amounts, as provided in this paragraph. This payment method is similar to that used by the Medicare program for ambulatory surgery. This paragraph applies to payment for institutional charges for ambulatory surgery provided in hospitals and freestanding ambulatory surgical centers. It does not apply to professional services. A list of ambulatory surgery procedures subject to the payment method set forth in this paragraph shall be published periodically by the Director OCHAMPUS. Payment to freestanding ambulatory surgery centers is limited to these procedures.

2. Payment in full. The payment provided for under this paragraph is the payment in full for services covered by this paragraph. Facilities may not charge beneficiaries for amounts, if any, in excess of the payment amounts determined pursuant to this paragraph.

3. Calculation of standard payment rates. Standard payment rates are calculated for groups of procedures under the following steps:

a. Step 1: calculate a median standardized cost for each procedure. For each ambulatory surgery procedure, a median standardized cost will be calculated on the basis of all ambulatory surgery charges nationally under CHAMPUS during a recent one-year base period. The steps in this calculation include standardizing for local labor costs by reference to the same wage index and labor/non-labor-related cost ratio as applies to the facility under Medicare, applying a cost-to-charge ratio, calculating a median cost for each procedure, and updating to the year for which the payment rates will be in effect by the Consumer Price Index-Urban. In applying a cost-to-charge ratio, the Medicare cost-to-charge ratio for freestanding ambulatory surgery centers (FASCs) will be used for all charges from FASCs, and the Medicare cost-to-charge ratio for hospital outpatient settings will be used for all charges from hospitals.

b. Step 2: grouping procedures. Procedures will then be placed into one of ten groups by their median per procedure cost, starting with \$0 to \$299 for group 1 and ending with \$1000 to \$1299 for group 9 and \$1300 and above for group 10, with groups 2 through 8 set on the basis of \$100 fixed intervals.

c. Step 3: adjustments to groups. The Director, OCHAMPUS may make adjustments to the groupings resulting from step 2 to account for any ambulatory surgery procedures for which there were insufficient data to allow a grouping or to correct for any anomalies resulting from data or statistical factors or other special factors that fairness requires be specially recognized. In making any such adjustments, the Director may take into consideration the placing of particular procedures in the ambulatory surgery groups under Medicare.

d. Step 4: standard payment amount per group. The standard payment amount per group will be the volume weighted median per procedure cost for the procedures in that group.

e. Step 5: actual payments. Actual payment for a procedure will be the standard payment amount for the group which covers that procedure, adjusted for local labor costs by reference to the same labor/non-labor-related cost ratio and hospital wage index as used for ambulatory surgery centers by Medicare.

4. Multiple procedures. In cases in which authorized multiple procedures are performed during the same operative session, payment shall be based on 100 percent of the payment amount for the procedure with the highest ambulatory surgery payment amount, plus, for each other procedure performed during the session, 50 percent of its payment amount.

5. Annual updates. The standard payment amounts will be updated annually by the same update factor as is used in the Medicare annual updates for ambulatory surgery center payments.

6. Recalculation of rates. The Director, OCHAMPUS, may periodically recalculate standard payment rates for ambulatory surgery using the steps set forth in paragraph D.3., of this Chapter.

E. REIMBURSEMENT OF BIRTHING CENTERS

1. Reimbursement for maternity care and childbirth services furnished by an authorized birthing center shall be limited to the lower of the CHAMPUS established all-inclusive rate or the center's most-favored all-inclusive rate.

2. The all-inclusive rate shall include the following to the extent that they are usually associated with a normal pregnancy and childbirth: laboratory studies, prenatal management, labor management, delivery, post-partum management, newborn care, birth assistant, certified nurse-midwife professional services, physician professional services, and the use of the facility.

3. The CHAMPUS established all-inclusive rate is equal to the sum of the CHAMPUS area prevailing professional charge for total obstetrical care for a normal pregnancy and delivery and the sum of the average CHAMPUS allowable institutional charges for supplies, laboratory, and delivery room for a hospital inpatient normal

delivery. The CHAMPUS established all-inclusive rate areas will coincide with those established for prevailing professional charges and will be updated concurrently with the CHAMPUS area prevailing professional charge database.

4. Extraordinary maternity care services, when otherwise authorized, may be reimbursed at the lesser of the billed charge or the CHAMPUS allowable charge.

RESERVED

G. REIMBURSEMENT OF INDIVIDUAL HEALTH-CARE PROFESSIONALS AND OTHER
NON-INSTITUTIONAL HEALTH-CARE PROVIDERS

The CHAMPUS-determined reasonable charge (the amount allowed by CHAMPUS) for the service of an individual health-care professional or other non-institutional health-care provider (even if employed by or under contract to an institutional provider) shall be determined by one of the following methodologies, that is, whichever is in effect in the specific geographic location at the time covered services and supplies are provided to a CHAMPUS beneficiary.

1. Allowable charge method.

a. Introduction

(1) In general. The allowable charge method is the preferred and primary method for reimbursement of individual health care professionals and other non-institutional health care providers covered by 10 U.S.C. 1079(h)(1)). The allowable charge for authorized care shall be the lower of the billed charge or the local CHAMPUS Maximum Allowable Charge (CMAC) level.

(2) CHAMPUS Maximum Allowable Charge. Beginning in calendar year 1992, prevailing charge levels and appropriate charge levels will be calculated on a national level. There will then be calculated a national CHAMPUS Maximum Allowable Charge (CMAC) level for each procedure, which shall be the lesser of the national prevailing charge level or the national appropriate charge level. The national CMAC will then be adjusted for localities in accordance with paragraph G.1.d., of this Chapter.

(3) Differential for Participating Providers. Beginning in calendar year 1994, there shall be a differential in national and local CMACs based on whether the provider is a participating provider or a nonparticipating provider. The differential shall be calculated so that the CMAC for the nonparticipating providers is 95 percent of the CMAC for the participating providers. To assure the effectiveness of the several phase-in and waiver provisions set forth in paragraphs G.1.c., and G.1.d., of this Chapter, beginning in calendar year 1994, there will first be calculated the national and local CMACs for nonparticipating providers. For purposes of this calculation, the identification of overpriced procedures called for in paragraph G.1.C.a., of this chapter and the calculation of appropriate charge levels for such overpriced procedures called for in paragraph G.1.D.(2), of this Chapter shall use as the Medicare fee component of the comparisons and calculations the fee level applicable to Medicare nonparticipating providers, which is 95 percent of the basic fee level. After nonparticipating provider local CMACs are calculated (including consideration of special phase-in rules and waiver rules in paragraph G.1.d., of this Chapter) participating provider local CMACs will be calculated so that nonparticipating provider local CMACs are 95 percent of participating provider local CMACs. (For more information on the Participating Provider Program, see Chapter 6.A.8).

(4) Limits on balance billing by nonparticipating providers. Nonparticipating providers may not balance bill a beneficiary an amount which exceeds the applicable balance billing limit. The balance billing limit shall be the same percentage as the Medicare limiting charge percentage for nonparticipating physicians. The balance billing limit may be waived by the Director, OCHAMPUS

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DEPARTMENT OF DEFENSE
PUBLICATION SYSTEM
CHANGE TRANSMITTAL

OFFICE OF THE SECRETARY OF DEFENSE
Assistant Secretary of Defense for Health Affairs

CHANGE NO. 7
to July 1991, Reprint
DoD 6010.8-R
October 21, 1994

CIVILIAN HEALTH AND MEDICAL PROGRAM
OF THE UNIFORMED SERVICES (CHAMPUS)

AD-A268034
The Assistant Secretary of Defense for Health Affairs has authorized the following changes to DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," July 1991 (Reprint).

PEN CHANGE

Change Transmittal No. 6, June 24, 1994, EFFECTIVE DATE, line 8. Change "May 22, 1995" to "May 22, 1994"

PAGE CHANGES

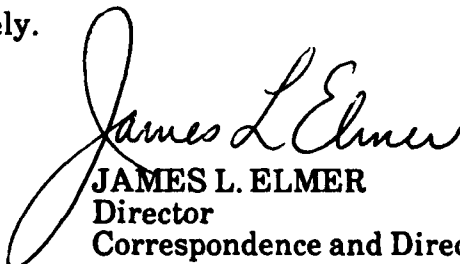
Remove: 4-vii&4-viii, 4-46&4-46a, 6-17&6-18, 10-7&10-8, 16-3

Insert: Attached replacement pages

Changes appear on pages 4-vii, 4-46, 6-17, 10-3, 10-7, and 16-3 and are indicated by marginal bars.

EFFECTIVE DATE

The above changes are effective immediately.


JAMES L. ELMER
Director
Correspondence and Directives

Attachments
9 pages

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, THIS TRANSMITTAL SHOULD BE FILED WITH THE BASIC DOCUMENT

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5. Cost-Sharing under the Military-Civilian Health Services Partnership Program. Cost-sharing is dependent upon the type of partnership program entered into, whether external or internal. (See section P. of Chapter 1, for general requirements of the Military-Civilian Health Services Partnership Program.)

a. External Partnership Agreement. Authorized costs associated with the use of the civilian facility will be financed through CHAMPUS under the normal cost-sharing and reimbursement procedures applicable under CHAMPUS.

b. Internal Partnership Agreement. Beneficiary cost-share under internal agreements will be the same as charges prescribed for care in military treatment facilities.

6. [Reserved]

7. [Reserved]

8. Cost-sharing for services provided under special discount arrangements.

a. General rule. With respect to services determined by the Director, OCHAMPUS (or designee) to be covered by Chapter 14, section I., the Director, OCHAMPUS (or designee) has authority to establish, as an exception to the cost-sharing amount normally required pursuant to this chapter, a different cost-share amount that appropriately reflects the application of the statutory cost-share to the discount arrangement.

b. Specific applications. The following are examples of applications of the general rule; they are not all inclusive.

(1) In the case of services provided by individual health care professionals and other noninstitutional providers, the cost-share shall be the usual percentage of the CHAMPUS allowable charge determined under Chapter 14, section I.

(2) In the case of services provided by institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under Chapter 14, section A.1. or per-diem amount under Chapter 14, section A.2.), if the discount rate is lower than the pre-set rate, the cost-share amount that would apply for a beneficiary other than an active duty dependent pursuant to the normal pre-set rate would be reduced by the same percentage by which the pre-set rate was reduced in setting the discount rate.

9. Waiver of deductible amounts or cost-sharing not allowed.

a. General rule. Because deductible amounts and cost sharing are statutorily mandated, except when specifically authorized by law (as determined by the Director, OCHAMPUS), a provider may not waive or forgive beneficiary liability for annual deductible amounts or inpatient or outpatient cost-sharing, as set forth in this chapter.

b. Exception for bad debts. This general rule is not violated in cases in which a provider has made all reasonable attempts to effect collection, without success, and determines in accordance with generally accepted fiscal management standards that the beneficiary liability in a particular case is an uncollectible bad debt.

c. Remedies for noncompliance. Potential remedies for noncompliance with this requirement include:

(1) A claim for services regarding which the provider has waived the beneficiary's liability may be disallowed in full, or, alternatively, the amount payable for such a claim may be reduced by the amount of the beneficiary liability waived.

NOTE: An infirmary in a boarding school also may qualify under this provision, subject to review and approval by the Director, OCHAMPUS, or a designee.

j. Other special institutional providers.

(1) General

(a) Care provided by certain special institutional providers (on either an inpatient or outpatient basis), may be cost-shared by CHAMPUS under specified circumstances and only if the provider is specifically identified in paragraph B.4.j. of this Chapter.

1 The course of treatment is prescribed by a doctor of medicine or osteopathy.

2 The patient is under the supervision of a physician during the entire course of the inpatient admission or the outpatient treatment.

3 The type and level of care and service rendered by the institution are otherwise authorized by this Regulation.

4 The facility meets all licensing or other certification requirements that are extant in the jurisdiction in which the facility is located geographically.

5 Is other than a nursing home, intermediate care facility, home for the aged, halfway house, or other similar institution.

6 Is accredited by the JCAHO or other CHAMPUS-approved accreditation organization, if an appropriate accreditation program for the given type of facility is available. As future accreditation programs are developed to cover emerging specialized treatment programs, such accreditation will be a prerequisite to coverage by CHAMPUS for services provided by such facilities.

(b) To ensure that CHAMPUS beneficiaries are provided quality care at a reasonable cost when treated by a special institutional provider, the Director, OCHAMPUS, may:

1 Require prior approval of all admissions to special institutional providers.

2 Set appropriate standards for special institutional providers in addition to or in the absence of JCAHO accreditation.

3 Monitor facility operations and treatment programs on a continuing basis and conduct onsite inspections on a scheduled and unscheduled basis.

4 Negotiate agreements of participation.

5 Terminate approval of a case when it is ascertained that a departure from the facts upon which the admission was based originally has occurred.

6 Declare a special institutional provider not eligible for CHAMPUS payment if that facility has been found to have engaged in fraudulent or deceptive practices.

(c) In general, the following disclaimers apply to treatment by special institutional providers:

1 Just because one period or episode of treatment by a facility has been covered by CHAMPUS may not be construed to mean that later episodes of care by the same or similar facility will be covered automatically.

2 The fact that one case has been authorized for treatment by a specific facility or similar type of facility may not be construed to mean that similar cases or later periods of treatment will be extended CHAMPUS benefits automatically.

(2) Types of providers. The following is a list of facilities that have been designated specifically as special institutional providers.

(a) Free-standing ambulatory surgical centers. Care provided by freestanding ambulatory surgical centers may be cost-shared by CHAMPUS under the following circumstances:

1 The treatment is prescribed and supervised by a physician.

2 The type and level of care and services rendered by the center are otherwise authorized by this Regulation.

3 The center meets all licensing or other certification requirements of the jurisdiction in which the facility is located.

4 The center is accredited by the JCAHO, the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), or such other standards as authorized by the Director, OCHAMPUS.

5 A childbirth procedure provided by a CHAMPUS-approved free-standing ambulatory surgical center shall not be cost-shared by CHAMPUS unless the surgical center is also a CHAMPUS-approved birthing center institutional provider as established by the birthing center provider certification requirement of this Regulation.

4. Notice of reconsideration determination. OCHAMPUSEUR, the CHAMPUS contractor, or the CHAMPUS peer review organization shall issue a written notice of the reconsideration determination to the appealing party at his or her last known address. The notice of the reconsideration determination must contain the following elements:

- a. A statement of the issue or issues under appeal.
- b. The provisions of law, regulation, policies, and guidelines that apply to the issue or issues under appeal.
- c. A discussion of the original and additional information that is relevant to the issue or issues under appeal.
- d. Whether the reconsideration upholds the initial determination or reverses it, in whole or in part, and the rationale for the action.
- e. A statement of the right to appeal further in any case when the reconsideration determination is less than fully favorable to the appealing party and the amount in dispute is \$50 or more.

5. Effect of reconsideration determination. The reconsideration determination is final if either of the following exist:

- a. The amount in dispute is less than \$50.
- b. Appeal rights have been offered, but a request for formal review is not received by OCHAMPUS within 60 days of the date of the notice of the reconsideration determination.

C. FORMAL REVIEW

Except as explained below, any party to an initial determination made by OCHAMPUS, or a reconsideration determination made by the CHAMPUS contractor may request a formal review by OCHAMPUS if the party is dissatisfied with the initial or reconsideration determination unless the initial or reconsideration determination (1) is final under paragraph (B)(5) above; (2) involves the sanctioning of a provider by the exclusion, suspension or termination of authorized provider status; (3) involves a written decision issued pursuant to Section 199.9, paragraph (h)(1)(iv)(A) regarding the temporary suspension of claims processing; or (4) involves a reconsideration determination by a CHAMPUS peer review organization. A hearing, but not a formal review level of appeal, may be available to a party to an initial determination involving the sanctioning of a provider or to a party to a written decision involving a temporary suspension of claims processing. A beneficiary (or an authorized representative of a beneficiary), but not a provider, may request a hearing, but not a formal review, of a reconsideration determination made by a CHAMPUS peer review organization.

1. Requesting a formal review

- a. Written request required. The request must be in writing, shall state the specific matter in dispute, shall include copies of the written determination

(notice of reconsideration determination or OCHAMPUS initial determination) being appealed, and shall include any additional information or documents not submitted previously.

b. Where to file. The request shall be submitted to the Chief, Appeals and Hearings, OCHAMPUS, Aurora, Colorado 80045-6900.

c. Allowed time to file. The request shall be mailed within 60 days after the date of the notice of the reconsideration determination or OCHAMPUS initial determination being appealed.

d. Official filing date. A request for a formal review shall be deemed filed on the date it is mailed and postmarked. If the request does not have a postmark, it shall be deemed filed on the date received by OCHAMPUS.

2. The formal review process. The purpose of the formal review is to determine whether the initial determination or reconsideration determination was made in accordance with law, regulation, policies, and guidelines in effect at the time the care was provided or requested or at the time of the initial determination, reconsideration, or formal review decision involving a provider request for approval as an authorized CHAMPUS provider. The formal review is performed by the Chief, Appeals and Hearings, OCHAMPUS, or a designee, and is a thorough review of the case. The formal review determination shall be based on the information upon which the initial determination or reconsideration determination was based, and any additional information the appealing party may submit or OCHAMPUS may obtain.

3. Timeliness of formal review determination. The Chief, Appeals and Hearings, OCHAMPUS, or a designee, normally shall issue the formal review determination no later than 90 days from the date of receipt of the request for formal review by the OCHAMPUS.

4. Notice of formal review determination. The Chief, Appeals and Hearings, OCHAMPUS, or a designee, shall issue a written notice of the formal review determination to the appealing party at his or her last known address. The notice of the formal review determination must contain the following elements:

- a. A statement of the issue or issues under appeal.
- b. The provisions of law, regulation, policies, and guidelines that apply to the issue or issues under appeal.
- c. A discussion of the original and additional information that is relevant to the issue or issues under appeal.
- d. Whether the formal review upholds the prior determination or determinations or reverses the prior determination or determinations in whole or in part and the rationale for the action.
- e. A statement of the right to request a hearing in any case when the formal review determination is less than fully favorable, the issue is appealable, and the amount in dispute is \$300 or more.

F. Authorities.

1. The Uniformed Services may establish additional procedures, consistent with this chapter, for the effective administration of the supplemental care program in their respective services.

2. The Assistant Secretary of Defense for Health Affairs is responsible for the overall policy direction of the supplemental care program and the administration of this chapter.

3. The Director, OCHAMPUS shall issue procedural requirements for the implementation of this Chapter, including the requirement for claims submission similar to those established by Chapter 7.

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CHAPTER 4
BASIC PROGRAM BENEFITS

A. GENERAL

The CHAMPUS Basic Program is essentially a supplemental program to the Uniformed Services direct medical care system. The Basic Program is similar to private medical insurance programs, and is designed to provide financial assistance to CHAMPUS beneficiaries for certain prescribed medical care obtained from civilian sources.

1. Scope of benefits. Subject to all applicable definitions, conditions, limitations, or exclusions specified in this Regulation, the CHAMPUS Basic Program will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury, including maternity care and well-baby care. Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians, other authorized individual professional providers, and professional ambulance service, prescription drugs, authorized medical supplies, and rental or purchase of durable medical equipment.

2. Persons eligible for Basic Program benefits. Persons eligible to receive the Basic Program benefits are set forth in Chapter 3 of this Regulation. Any person determined to be an eligible CHAMPUS beneficiary is eligible for Basic Program benefits.

3. Authority to act for CHAMPUS. The authority to make benefit determinations and authorize the disbursement of funds under CHAMPUS is restricted to the Director, OCHAMPUS; designated OCHAMPUS staff; Director, OCHAMPUSEUR; or CHAMPUS fiscal intermediaries. No other persons or agents (such as physicians, staff members of hospitals, or CHAMPUS health benefits advisors) have such authority.

4. Status of patient controlling for purposes of cost-sharing. Benefits for covered services and supplies described in this chapter will be extended either on an inpatient or outpatient cost-sharing basis in accordance with the status of the patient at the time the covered services and supplies were provided, unless otherwise specifically designated (such as for ambulance service or maternity care). For cost-sharing provisions, refer to section F. of this chapter.

5. Right to information. As a condition precedent to the provision of benefits hereunder, OCHAMPUS or its CHAMPUS fiscal intermediaries shall be entitled to receive information from a physician or hospital or other person, institution, or organization (including a local, state, or U.S. Government agency) providing services or supplies to the beneficiary for which claim or requests for approval for benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, or examination or diagnosis of, or treatment rendered, or services and supplies furnished to a beneficiary, and shall be necessary for the accurate and efficient administration of CHAMPUS benefits. Before a determination will be made on a request for preauthorization or claim of benefits, a beneficiary or sponsor must provide particular additional information relevant to the requested determina-

tion, when necessary. The recipient of such information shall in every case hold such records confidential except when (a) disclosure of such information is authorized specifically by the beneficiary; (b) disclosure is necessary to permit authorized governmental officials to investigate and prosecute criminal actions, or (c) disclosure is authorized or required specifically under the terms of the Privacy Act or Freedom of Information Act (references (i) through (k)) (refer to section M. of chapter 1 of this Regulation). For the purposes of determining the applicability of and implementing the provisions of chapters 8, 11 and 12, or any provision of similar purpose of any other medical benefits coverage or entitlement, OCHAMPUS or CHAMPUS fiscal intermediaries may release, without consent or notice to any beneficiary or sponsor, to any person, organization, government agency, provider, or other entity any information with respect to any beneficiary when such release constitutes a routine use published in the Federal Register in accordance with DoD 5400.11-R (reference (k)). Before a person's claim of benefits will be adjudicated, the person must furnish to CHAMPUS information that reasonably may be expected to be in his or her possession and that is necessary to make the benefit determination. Failure to provide the requested information may result in denial of the claim.

6. Physical examinations. The Director, OCHAMPUS, or a designee, may require a beneficiary to submit to one or more medical (including psychiatric) examinations to determine the beneficiary's entitlement to benefits for which application has been made or for otherwise authorized medically necessary services and supplies required in the diagnosis or treatment of an illness or injury (including maternity and well-baby care). When a medical examination has been requested, CHAMPUS will withhold payment of any pending claims or preauthorization requests on that particular beneficiary. If the beneficiary refuses to agree to the requested medical examination, or unless prevented by a medical reason acceptable to OCHAMPUS, the examination is not performed within 90 days of initial request, all pending claims for services and supplies will be denied. A denial of payments for services or supplies provided before (and related to) the request for a physical examination is not subject to reconsideration. The medical examination and required beneficiary travel related to performing the requested medical examination will be at the expense of CHAMPUS. The medical examination may be performed by a physician in a Uniformed Services medical facility or by an appropriate civilian physician, as determined and selected by the Director, OCHAMPUS, or a designee who is responsible for making such arrangements as are necessary, including necessary travel arrangements.

7. Claims filing deadline. For all services provided on or after January 1, 1993, to be considered for benefits, all claims submitted for benefits, must, except as provided in Chapter 7, of this regulation, be filed with the appropriate CHAMPUS contractor no later than one year after the services are provided. Unless the requirement is waived, failure to file a claim within the deadline waives all rights to benefits for such services or supplies.

8. Double coverage and third party recoveries. CHAMPUS claims involving double coverage or the possibility that the United States can recover all or a part of its expenses from a third party, are specifically subject to the provisions of Chapter 8 or Chapter 12 of this Regulation as appropriate.

9. Nonavailability Statements within a 40-mile catchment area. In some geographic locations (or under certain special circumstances), it is necessary for a CHAMPUS beneficiary to determine whether the required medical care can be provided through a Uniformed Service facility. If the required medical care cannot be provided, the hospital commander, or a designee, will issue a Nonavailability Statement (DD Form 1251). Except for emergencies, a Nonavailability Statement should be issued before medical care is obtained from a civilian source. Failure to secure such a statement may waive the beneficiary's rights to benefits under CHAMPUS.

a. Rules applicable to issuance of Nonavailability Statement (DD Form 1251).

(1) The ASD(HA) is responsible for issuing rules and regulations regarding Nonavailability Statements.

(2) A Nonavailability Statement (NAS) is required for services in connection with nonemergency inpatient hospital care if such services are available at a facility of the Uniformed Services located within a 40-mile radius of the residence of the beneficiary, except that a NAS is not required for services otherwise available at a facility of the Uniformed Services located within a 40-mile radius of the beneficiary's residence when another insurance plan or program provides the beneficiary primary coverage for the services.

(3) An NAS is also required for selected outpatient procedures if such services are not available at a Uniformed Service facility (excluding facilities which are exclusively outpatient clinics) located within a 40-mile radius (catchment area) of the residence of the beneficiary. This does not apply to emergency services or for services for which another insurance plan or program provides the beneficiary primary coverage. Any changes to the selected outpatient procedures will be published in the Federal Register at least 30 days before the effective date of the change by the ASD(HA) and will be limited to the following categories: outpatient surgery and other selected outpatient procedures which have high unit costs and for which care may be available in military treatment facilities generally. The selected outpatient procedures will be uniform for all CHAMPUS beneficiaries.

(4) In addition to NAS requirements set forth in paragraph A.9, of this chapter, additional NAS requirements are established pursuant to paragraph A.10, of this chapter in connection with highly specialized care in national or 200 mile catchment areas of military or civilian Specialized Treatment Services Facilities.

b. Beneficiary responsibility. The beneficiary is responsible for securing information whether or not he or she resides in a geographic area that requires obtaining a Nonavailability Statement. Information concerning current rules and regulations may be obtained from the Offices of the Army, Navy, and Air Force Surgeon Generals; or a CHAMPUS health benefits advisor; or the Director, OCHAMPUS, or a designee; or from the appropriate CHAMPUS fiscal intermediary.

c. Rules in effect at time civilian medical care is provided apply. The applicable rules and regulations regarding Nonavailability Statements in effect at the time the civilian care is rendered apply in determining whether a Nonavailability Statement is required.

d. Nonavailability Statement (DD Form 1251) must be filed with applicable claim. When a claim is submitted for CHAMPUS benefits that includes services for which a Nonavailability Statement was issued, a valid Nonavailability Statement authorization must be on DEERS.

e. Nonavailability Statement (NAS) and claims adjudication.

(1) A NAS is valid for the adjudication of CHAMPUS claims for all related care otherwise authorized by this Regulation which is received from a civilian source while the beneficiary resided within the Uniformed Service facility catchment area which issued the NAS.

(2) A requirement for a NAS for inpatient hospital maternity care must be met for CHAMPUS cost-share of any related outpatient maternity care.

10. Nonavailability Statements in national or 200-mile catchment areas for highly specialized care available in selected military or civilian Specialized Treatment Service Facilities.

a. Specialized Treatment Service Facilities. STS Facilities may be designated for certain high cost, high technology procedures. The purpose of such designations is to concentrate patient referrals for certain highly specialized procedures which are of relatively low incidence and/or relatively high per case cost and which require patient concentration to permit resource investment and enhance the effectiveness of quality assurance efforts.

b. Designation. Selected military treatment facilities and civilian facilities will be designated by the Assistant Secretary of Defense for Health Affairs as STS Facilities for certain procedures. These designations will be based on the highly specialized capabilities of these selected facilities. For each STS designation for which NASs in national or 200-mile catchment areas will be required, there shall be a determination that total government costs associated with providing the service under the Specialized Treatment Services program will in aggregate be less than the total government cost of that service under the normal operation of CHAMPUS. There shall also be a determination that the Specialized Treatment Services Facility meets a standard of excellence in quality comparable to that prevailing in other specialized medical centers in the nation or region that provide the services involved.

c. Organ transplants and similar procedures. For organ transplants and procedures of similar extraordinary specialization, military or civilian STS Facilities may be designated for a nationwide catchment area, covering all 50 states, the District of Columbia and Puerto Rico (or, alternatively, for any portion of such a nationwide area).

d. Other highly specialized procedures. For other highly specialized procedures, military or civilian STS Facilities will be designated for catchment areas of up to approximately 200 miles radius. The exact geographical area covered for each STS Facility will be identified by reference to State and local

governmental jurisdictions, zip code groups or other method to describe an area within an approximate radius of 200 miles from the facility. In paragraph A.10 of this chapter, this catchment area is referred to as a "200-mile catchment area".

e. NAS requirement. For procedures subject to a nationwide catchment area NAS requirement under paragraph A.10.c of this chapter or a 200-mile catchment area NAS requirement under paragraph A.10.d of this chapter CHAMPUS cost sharing is not allowed unless the services are obtained from a designated civilian Specialized Treatment Services program (as authorized) or an NAS has been issued. This rule is subject to the exception set forth in paragraph A.10.f of this chapter. This NAS requirement is a general requirement of the CHAMPUS program.

f. Exceptions. Nationwide catchment area NASs and 200-mile catchment area NASs are not required in any of the following circumstances:

- (1) An emergency.
- (2) When another insurance plan or program provides the beneficiary primary coverage for the services.
- (3) A case-by-case waiver is granted based on a medical judgment made by the commander of the STS Facility (or other person designated for this purpose) that, although the care is available at the facility, it would be medically inappropriate because of a delay in the treatment or other special reason to require that the STS Facility be used; or
- (4) A case-by-case waiver is granted by the commander of the STS Facility (or other person designated for this purpose) that, although the care is available at the facility, use of the facility would impose exceptional hardship on the beneficiary or the beneficiary's family.

g. Waiver process. A process shall be established for beneficiaries to request a case-by-case waiver under paragraphs A.10.f.(3)(4) of this chapter. This process shall include:

- (1) An opportunity for the beneficiary (and/or the beneficiary's physician) to submit information the beneficiary believes justifies a waiver.
- (2) A written decision from a person designated for the purpose on the request for a waiver, including a statement of the reasons for the decision.
- (3) An opportunity for the beneficiary to appeal an unfavorable decision to a designated appeal authority not involved in the initial decision; and
- (4) A written decision on the appeal, including a statement of the reasons for the decision.

h. Notice. The Assistant Secretary of Defense for Health Affairs will annually publish in the Federal Register a notice of all military and civilian STS Facilities, including a listing of the several procedures subject to nationwide catchment area NASs and the highly specialized procedures subject to 200-mile catchment area NASs.

i. Specialized procedures. Highly specialized procedures that may be established as subject to 200-mile catchment area NASs are limited to:

(1) Medical and surgical diagnoses requiring inpatient hospital treatment of an unusually intensive nature, documented by a DRG-based payment system weight (pursuant to Chapter 14, paragraph A.1) for a single DRG or an aggregated DRG weight for a category of DRGs of at least 2.0 (i.e., treatment is at least two times as intensive as the average CHAMPUS inpatient case).

(2) Diagnostic or therapeutic services, including outpatient services, related to such inpatient categories of treatment.

(3) Other procedures which require highly specialized equipment the cost of which exceeds \$1,000,000 (e.g., lithotripter, positron emission tomography equipment) and such equipment is underutilized in the area; and

(4) Other comparable highly specialized procedures as determined by the Assistant Secretary of Defense for Health Affairs.

j. Quality standards. Any facility designated as a military or civilian STS Facility under paragraph A.10 of this chapter shall be required to meet quality standards established by the Assistant Secretary of Defense for Health Affairs. In the development of such standards, the Assistant Secretary shall consult with relevant medical speciality societies and other appropriate parties. To the extent feasible, quality standards shall be based on nationally recognized standards.

k. NAS procedures. The provisions of paragraphs A.9.b through A.9.e of this chapter regarding procedures applicable to NASs shall apply to expanded catchment area NASs required by paragraph A.10 of this chapter.

l. Travel and lodging expenses. In accordance with guidelines issued by the Assistant Secretary of Defense for Health Affairs, certain travel and lodging expenses associated with services under the Specialized Treatment Services program may be fully or partially reimbursed.

m. Preference for military facility use. In any case in which services subject to an NAS requirement under paragraph A.10 of this chapter are available in both a military STS Facility and from a civilian STS Facility, the military Facility must be used unless use of the civilian Facility is specifically authorized.

11. Quality and Utilization Review Peer Review Organization program. All benefits under the CHAMPUS program are subject to review under the CHAMPUS Quality and Utilization Review Peer Review Organization program pursuant to Chapter 15. Utilization and quality review of mental health services are also part of the Peer Review Organization program, and are addressed in paragraph A.12 of this chapter.)

12. Utilization review, quality assurance and preauthorization for inpatient mental health services.

a. In general. The Director, OCHAMPUS shall provide, either directly or through contract, a program of utilization and quality review for all mental health care services. Among other things, this program shall include mandatory

preadmission authorization before nonemergency inpatient mental health services may be provided and mandatory approval of continuation of inpatient services within 72 hours of emergency admissions. This program shall also include requirements for other pretreatment authorization procedures, concurrent review of continuing inpatient and partial hospitalization care, retrospective review, and other such procedures as determined appropriate by the Director, OCHAMPUS. The provisions of paragraph H of this chapter and paragraph F, Chapter 15, shall apply to this program. The Director, OCHAMPUS, shall establish, pursuant to paragraph F., Chapter 15, procedures substantially comparable to requirements of paragraph H of this chapter and Chapter 15. If the utilization and quality review program for mental health care services is provided by contract, the contractor(s) need not be the same contractor(s) as are engaged under Chapter 15 in connection with the review of other services.

b. Preadmission authorization.

(1) This section generally requires preadmission authorization for all nonemergency inpatient mental health services and prompt continued stay authorization after emergency admissions. It also requires preadmission authorization for all admissions to a partial hospitalization program, without exception, as the concept of an emergency admission does not pertain to a partial hospitalization level of care. Institutional services for which payment would otherwise be authorized, but which were provided without compliance with preadmission authorization requirements, do not qualify for the same payment that would be provided if the preadmission requirements had been met.

(2) In cases of noncompliance with preauthorization requirements, a payment reduction shall be made in accordance with Chapter 15, paragraph B.4.c.

(3) For purposes of paragraph A.12.b.(2) of this chapter, a day of services without the appropriate preauthorization is any day of services provided prior to:

(a) the receipt of an authorization; or

(b) the effective date of an authorization subsequently received.

(4) Services for which payment is disallowed under paragraph A.12.b.(2) of this chapter may not be billed to the patient (or the patient's family).

13. Implementing instructions. The Director, OCHAMPUS, shall issue policies, procedures, instructions, guidelines, standards, and/or criteria to implement this chapter.

B. INSTITUTIONAL BENEFITS

1. General. Services and supplies provided by an institutional provider authorized as set forth in Chapter 6 of this Regulation may be cost-shared only when such services or supplies (i) are otherwise authorized by this Regulation; (ii) are medically necessary; (iii) are ordered, directed, prescribed, or delivered by an

OCHAMPUS-authorized individual professional provider as set forth in Chapter 6 of this Regulation or by an employee of the authorized institutional provider who is otherwise eligible to be a CHAMPUS authorized individual professional provider; (iv) are delivered in accordance with generally accepted norms for clinical practice in the United States; (v) meet established quality standards; and (vi) comply with applicable definitions, conditions, limitations, exceptions, or exclusions as otherwise set forth in this Regulation.

a. Billing practices. To be considered for benefits under this section B., covered services and supplies must be provided and billed for by a hospital or other authorized institutional provider. Such billings must be fully itemized and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. Depending on the individual circumstances, teaching physician services may be considered an institutional benefit in accordance with this Section or a professional benefit under Section C. See paragraph C.3.m. of the Chapter for the CHAMPUS requirements regarding teaching physicians. In the case of continuous care, claims shall be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor or, on a participating basis, directly by the facility on behalf of the beneficiary (refer to Chapter 7).

b. Successive inpatient admissions. Successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the active duty dependent's share of the inpatient institutional charges, provided not more than 60 days have elapsed between the successive admissions, except that successive inpatient admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions. For the purpose of applying benefits, successive admissions will be determined separately for maternity admissions and admissions related to an accidental injury (refer to section F. of this chapter).

c. Related services and supplies. Covered services and supplies must be rendered in connection with and related directly to a covered diagnosis or definitive set of symptoms requiring otherwise authorized medically necessary treatment.

d. Inpatient, appropriate level required. For purposes of inpatient care, the level of institutional care for which Basic Program benefits may be extended must be at the appropriate level required to provide the medically necessary treatment except for patients requiring skilled nursing facility care. For patients for whom skilled nursing facility care is adequate, but is not available in the general locality, benefits may be continued in the higher level care facility. General locality means an area that includes all the skilled nursing facilities within 50 miles of the higher level facility, unless the higher level facility can demonstrate that the skilled nursing facilities are inaccessible to its patients. The decision as to whether a skilled nursing facility is within the higher level facility's general locality, or the skilled nursing facility is inaccessible to the higher level facility's patients shall be a CHAMPUS contractor initial determination for the purposes of appeal under chapter 10 of this regulation. CHAMPUS institutional benefit payments shall be limited to the

allowable cost that would have been incurred in the skilled nursing facility, as determined by the Director, OCHAMPUS, or a designee. If it is determined that the institutional care can be provided reasonably in the home setting, no CHAMPUS institutional benefits are payable.

e. General or special education not covered. Services and supplies related to the provision of either regular or special education generally are not covered. Such exclusion applies whether a separate charge is made for education or whether it is included as a part of an overall combined daily charge of an institution. In the latter instance, that portion of the overall combined daily charge related to education must be determined, based on the allowable costs of the educational component, and deleted from the institution's charges before CHAMPUS benefits can be extended. The only exception is when appropriate education is not available from or not payable by the cognizant public entity. Each case must be referred to the Director, OCHAMPUS, or a designee, for review and a determination of the applicability of CHAMPUS benefits.

2. Covered hospital services and supplies

a. Room and board. Includes special diets, laundry services, and other general housekeeping support services (inpatient only).

b. General staff nursing services.

c. ICU. Includes specialized units, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery (inpatient only).

d. Operating room, recovery room. Operating room and recovery room, including other special treatment rooms and equipment, and hyperbaric chamber.

e. Drugs and medicines. Includes sera, biologicals, and pharmaceutical preparations (including insulin) that are listed in the official formularies of the institution or facility at the time of use. (To be considered as an inpatient supply, drugs and medicines must be consumed during the specific period the beneficiary is a registered inpatient. Drugs and medicines prescribed for use outside the hospital, even though prescribed and obtained while still a registered inpatient, will be considered outpatient supplies and the provisions of section D. of this chapter will apply.)

f. Durable medical equipment, medical supplies, and dressings. Includes durable medical equipment, medical supplies essential to a surgical procedure (such as artificial heart valve and artificial ball and socket joint), sterile trays, casts, and orthopedic hardware. Use of durable medical equipment is restricted to an inpatient basis.

NOTE: If durable medical equipment is to be used on an outpatient basis or continued in outpatient status after use as an inpatient, benefits will be provided as set forth in section D. of this chapter and cost-sharing will be on an outpatient basis (refer to subsection A.4. of this chapter).

g. Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results. Also includes CT scanning under certain limited conditions.

h. Anesthesia. Includes both the anesthetic agent and its administration.

i. Blood. Includes blood, plasma and its derivatives, including equipment and supplies, and its administration.

j. Radiation therapy. Includes radioisotopes.

k. Physical therapy.

l. Oxygen. Includes equipment for its administration.

m. Intravenous injections. Includes solution.

n. Shock therapy.

o. Chemotherapy.

p. Renal and peritoneal dialysis.

q. Psychological evaluation tests. When required by the diagnosis.

r. Other medical services. Includes such other medical services as may be authorized by the Director, OCHAMPUS, or a designee, provided they are related directly to the diagnosis or definitive set of symptoms and rendered by a member of the institution's medical or professional staff (either salaried or contractual) and billed for by the hospital.

3. Covered services and supplies provided by special medical treatment institutions or facilities, other than hospitals or RTCs

a. Room and board. Includes special diets, laundry services, and other general housekeeping support services (inpatient only).

b. General staff nursing services.

c. Drugs and medicines. Includes sera, biologicals, and pharmaceutical preparations (including insulin) that are listed in the official formularies of the institution or facility at the time of use. (To be considered as an inpatient supply, drugs and medicines must be consumed during the specific period the beneficiary is a registered inpatient. Drugs and medicines prescribed for use outside the authorized institutional provider, even though prescribed and obtained while still a registered inpatient, will be considered outpatient supplies and the provisions of section D. of this chapter will apply.)

d. Durable medical equipment, medical supplies, and dressings. Includes durable medical equipment, sterile trays, casts, orthopedic hardware and dressings. Use of durable medical equipment is restricted to an inpatient basis.

NOTE: If the durable medical equipment is to be used on an outpatient basis or continued in outpatient status after use as an inpatient, benefits will be provided as set forth in section D. of this chapter, and cost-sharing will be on an outpatient basis (refer to subsection A.4. of this chapter).

e. Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results.

f. Blood. Includes blood, plasma and its derivatives, including equipment and supplies, and its administration.

g. Physical therapy.

h. Oxygen. Includes equipment for its administration.

i. Intravenous injections. Includes solution.

j. Shock therapy.

k. Chemotherapy.

l. Psychological evaluation tests. When required by the diagnosis.

m. Renal and peritoneal dialysis.

n. Other medical services. Other medical services may be authorized by the Director, OCHAMPUS, or a designee, provided they are related directly to the diagnosis or definitive set of symptoms and rendered by a member of the institution's medical or professional staff (either salaried or contractual) and billed for by the authorized institutional provider of care.

4. Services and supplies provided by RTCs

a. Room and board. Includes use of residential facilities such as food service (including special diets), laundry services, supervised reasonable recreational and social activity services, and other general services as considered appropriate by the Director, OCHAMPUS, or a designee.

b. Patient assessment. Includes the assessment of each child or adolescent accepted by the RTC, including clinical consideration of each of his or her fundamental needs, that is, physical, psychological, chronological age, developmental level, family, educational, social, environmental, and recreational.

c. Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results.

d. Psychological evaluation tests.

e. Treatment of mental disorders. Services and supplies that are medically or psychologically necessary to diagnose and treat the mental disorder for which the patient was admitted to the RTC. Covered services and requirements for qualifications of providers are as listed in paragraph C.3.i. of this chapter.

f. Other necessary medical care. Emergency medical services or other authorized medical care may be rendered by the RTC provided it is professionally capable of rendering such services and meets standards required by the Director, OCHAMPUS. It is intended, however, that CHAMPUS payments to an RTC should primarily cover those services and supplies directly related to the treatment of mental disorders that require residential care.

g. Criteria for determining medical or psychological necessity. In determining the medical or psychological necessity of services and supplies provided by RTCs, the evaluation conducted by the Director, OCHAMPUS (or designee) shall consider the appropriate level of care for the patient, the intensity of services required by the patient, and the availability of that care. In addition to the criteria set forth in this paragraph B.4. of this chapter, additional evaluation standards, consistent with such criteria, may be adopted by the Director, OCHAMPUS (or designee). RTC services and supplies shall not be considered medically or psychologically necessary unless, at a minimum, all the following criteria are clinically determined in the evaluation to be fully met:

(1) Patient has a diagnosable psychiatric disorder.

(2) Patient exhibits patterns of disruptive behavior with evidence of disturbances in family functioning or social relationships and persistent psychological and/or emotional disturbances.

(3) RTC services involve active clinical treatment under an individualized treatment plan that provides for:

(a) Specific level of care, and measurable goals/objectives relevant to each of the problems identified;

(b) Skilled interventions by qualified mental health professionals to assist the patient and/or family;

(c) Time frames for achieving proposed outcomes; and

(d) Evaluation of treatment progress to include timely reviews and updates as appropriate of the patient's treatment plan that reflects alterations in the treatment regimen, the measurable goals/objectives, and the level of care required for each of the patient's problems, and explanations of any failure to achieve the treatment goals/objectives.

(4) Unless therapeutically contraindicated, the family and/or guardian must actively participate in the continuing care of the patient either through direct involvement at the facility or geographically distant family therapy. (In the latter case, the treatment center must document that there has been collaboration with the family and/or guardian in all reviews.)

h. Preauthorization requirement.

(1) All admissions to RTC care are elective and must be certified as medically/psychologically necessary prior to admission. The criteria for preauthorization shall be those set forth in paragraph B.4.g. of this chapter. In applying those criteria in the context of preadmission authorization review, special emphasis is placed on the development of a specific diagnosis/treatment plan, consistent with those criteria and reasonably expected to be effective, for that individual patient.

(2) The timetable for development of the individualized treatment plan shall be as follows:

(a) The plan must be under development at the time of the admission.

(b) A preliminary treatment plan must be established within 24 hours of the admission.

(c) A master treatment plan must be established within ten calendar days of the admission.

(3) The elements of the individualized treatment plan must include:

(a) The diagnostic evaluation that establishes the necessity for the admission;

(b) An assessment regarding the inappropriateness of services at a less intensive level of care;

(c) A comprehensive, biopsychosocial assessment and diagnostic formulation;

(d) A specific individualized treatment plan that integrates measurable goals/objectives and their required level of care for each of the patient's problems that are a focus of treatment;

(e) A specific plan for involvement of family members, unless therapeutically contraindicated; and

(f) A discharge plan, including an objective of referring the patient to further services, if needed, at less intensive levels of care within the benefit limit period.

(4) Preauthorization requests should be made not fewer than two business days prior to the planned admission. In general, the decision regarding preauthorization shall be made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. Pre-authorizations are valid for the period of time, appropriate to the type of care involved, stated when the preauthorization is issued. In general, pre-authorizations are valid for 30 days.

i. Concurrent review. Concurrent review of the necessity for continued stay will be conducted no less frequently than every 30 days. The criteria for concurrent review shall be those set forth in paragraph B.4.g. of this chapter. In applying those criteria in the context of concurrent review, special emphasis is placed on evaluating the progress being made in the active individualized clinical treatment being provided and on developing appropriate discharge plans.

5. Extent of institutional benefits

a. Inpatient room accommodations

(1) Semiprivate. The allowable costs for room and board furnished an individual patient are payable for semiprivate accommodations in a hospital or other authorized institution, subject to appropriate cost-sharing provisions (refer to section F. of this chapter). A semiprivate accommodation is a room containing at least two beds. Therefore, if a room publicly is designated by the institution as a semiprivate accommodation and contains multiple beds, it qualifies as semiprivate for the purpose of CHAMPUS.

(2) Private. A room with one bed that is designated as a private room by the hospital or other authorized institutional provider. The allowable cost of a private room accommodation is covered only under the following conditions:

(a) When its use is required medically and when the attending physician certifies that a private room is necessary medically for the proper care and treatment of a patient; or

(b) When a patient's medical condition requires isolation;
or

(c) When a patient (in need of immediate inpatient care but not requiring a private room) is admitted to a hospital or other authorized institution that has semiprivate accommodations, but at the time of admission, such accommodations are occupied; or

(d) When a patient is admitted to an acute care hospital (general or special) without semiprivate rooms.

(3) Duration of private room stay. The allowable cost of private accommodations is covered under the circumstances described in subparagraph B.5.a.(2) of this chapter until the patient's condition no longer requires the private room for medical reasons or medical isolation; or, in the case

of the patient not requiring a private room, when a semiprivate accommodation becomes available; or, in the case of an acute care hospital (general or special) which does not have semiprivate rooms, for the duration of an otherwise covered inpatient stay.

(4) Hospital (except an acute care hospital, general or special) or other authorized institutional provider without semiprivate accommodations. When a beneficiary is admitted to a hospital (except an acute care hospital, general or special) or other institution that has no semiprivate accommodations, for any inpatient day when the patient qualifies for use of a private room (as set forth in subparagraphs B.5.a.(2)(a) and (b), above), the allowable cost of private accommodations is covered. For any inpatient day in such a hospital or other authorized institution when the patient does not require medically the private room, the allowable cost of semiprivate accommodations is covered, such allowable costs to be determined by the Director, OCHAMPUS, or a designee.

b. General staff nursing services. General staff nursing services cover all nursing care (other than that provided by private duty nurses) including, but not limited to, general duty nursing, emergency room nursing, recovery room nursing, intensive nursing care, and group nursing arrangements. Only nursing services provided by nursing personnel on the payroll of the hospital or other authorized institution are eligible under this section B. If a nurse who is not on the payroll of the hospital or other authorized institution is called in specifically to care for a single patient (individual nursing) or more than one patient (group nursing), whether the patient is billed for the nursing services directly or through the hospital or other institution, such services constitute private duty (special) nursing services and are not eligible for benefits under this paragraph (the provisions of paragraph C.2.o. of this chapter would apply).

c. ICU. An ICU is a special segregated unit of a hospital in which patients are concentrated, by reason of serious illness, usually without regard to diagnosis. Special lifesaving techniques and equipment are available regularly and immediately within the unit, and patients are under continuous observation by a nursing staff specially trained and selected for the care of this type of patient. The unit is maintained on a continuing, rather than an intermittent or temporary, basis. It is not a postoperative recovery room or a postanesthesia room. In some large or highly specialized hospitals, the ICUs may be refined further for special purposes, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery. For purposes of CHAMPUS, these specialized units would be considered ICUs if they otherwise conformed to the definition of an ICU.

d. Treatment rooms. Standard treatment rooms include emergency rooms, operating rooms, recovery rooms, special treatment rooms, and hyperbaric chambers and all related necessary medical staff and equipment. To be recognized for purposes of CHAMPUS, treatment rooms must be so designated and maintained by the hospital or other authorized institution on a continuing basis. A treatment room set up on an intermittent or temporary basis would not be so recognized.

e. Drugs and medicines. Drugs and medicines are included as a supply of a hospital or other authorized institution only under the following conditions:

- (1) They represent a cost to the facility rendering treatment;
- (2) They are furnished to a patient receiving treatment, and are related directly to that treatment; and
- (3) They are ordinarily furnished by the facility for the care and treatment of inpatients.

f. Durable medical equipment, medical supplies, and dressings. Durable medical equipment, medical supplies, and dressings are included as a supply of a hospital or other authorized institution only under the following conditions:

- (1) If ordinarily furnished by the facility for the care and treatment of patients; and
- (2) If specifically related to, and in connection with, the condition for which the patient is being treated; and
- (3) If ordinarily furnished to a patient for use in the hospital or other authorized institution (except in the case of a temporary or disposable item); and
- (4) Use of durable medical equipment is limited to those items provided while the patient is an inpatient. If such equipment is provided for use on an outpatient basis, the provisions of section D. of this chapter apply.

g. Transitional use items. Under certain circumstances, a temporary or disposable item may be provided for use beyond an inpatient stay, when such item is necessary medically to permit or facilitate the patient's departure from the hospital or other authorized institution, or which may be required until such time as the patient can obtain a continuing supply; or it would be unreasonable or impossible from a medical standpoint to discontinue the patient's use of the item at the time of termination of his or her stay as an inpatient.

h. Anesthetics and oxygen. Anesthetics and oxygen and their administration are considered a service or supply if furnished by the hospital or other authorized institution, or by others under arrangements made by the facility under which the billing for such services is made through the facility.

6. Inpatient mental health services. Inpatient mental health services are those services furnished by institutional and professional providers for treatment of a nervous or mental disorder (as defined in Chapter 2) to a

patient admitted to a CHAMPUS-authorized acute care general hospital; a psychiatric hospital; or, unless otherwise exempted, a special institutional provider.

a. Criteria for determining medical or psychological necessity. In determining the medical or psychological necessity of acute inpatient mental health services, the evaluation conducted by the Director, OCHAMPUS (or designee) shall consider the appropriate level of care for the patient, the intensity of services required by the patient, and the availability of that care. The purpose of such acute inpatient care is to stabilize a life-threatening or severely disabling condition within the context of a brief, intensive model of inpatient care in order to permit management of the patient's condition at a less intensive level of care. Such care is appropriate only if the patient requires services of an intensity and nature that are generally recognized as being effectively and safely provided only in an acute inpatient hospital setting. In addition to the criteria set forth in this paragraph B.6. of this chapter, additional evaluation standards, consistent with such criteria, may be adopted by the Director, OCHAMPUS (or designee). Acute inpatient care shall not be considered necessary unless the patient needs to be observed and assessed on a 24-hour basis by skilled nursing staff, and/or requires continued intervention by a multidisciplinary treatment team; and in addition, at least one of the following criteria is determined to be met:

- (1) Patient poses a serious risk of harm to self and/or others.
- (2) Patient is in need of high dosage, intensive medication or somatic and/or psychological treatment, with potentially serious side effects.
- (3) Patient has acute disturbances of mood, behavior, or thinking.

b. Emergency admissions. Admission to an acute inpatient hospital setting may be on an emergency or on a non-emergency basis. In order for an admission to qualify as an emergency, the following criteria, in addition to those in paragraph B.6.a. of this chapter, must be met:

- (1) the patient must be at immediate risk of serious harm to self and or others based on a psychiatric evaluation performed by a physician (or other qualified mental health professional with hospital admission authority); and
- (2) the patient requires immediate continuous skilled observation and treatment at the acute psychiatric level of care.

c. Preauthorization requirements.

(1) All non-emergency admissions to an acute inpatient hospital level of care must be authorized prior to the admission. The criteria for preauthorization shall be those set forth in paragraph B.6.a. of this chapter. In applying those criteria in the context of preauthorization review, special emphasis is placed on the development of a specific individualized treatment plan, consistent with those criteria and reasonably expected to be effective, for that individual patient.

(2) The timetable for development of the individualized treatment plan shall be as follows:

(a) The development of the plan must begin immediately upon admission.

(b) A preliminary treatment plan must be established within 24 hours of the admission.

(c) A master treatment plan must be established within five calendar days of the admission.

(3) The elements of the individualized treatment plan must include:

(a) The diagnostic evaluation that establishes the necessity for the admission;

(b) An assessment regarding the inappropriateness of services at a less intensive level of care;

(c) A comprehensive biopsychosocial assessment and diagnostic formulation;

(d) A specific individualized treatment plan that integrates measurable goals/objectives and their required level of care for each of the patient's problems that are a focus of treatment;

(e) A specific plan for involvement of family members, unless therapeutically contraindicated; and

(f) A discharge plan, including an objective of referring the patient to further services, if needed, at less intensive levels of care within the benefit limit period.

(4) The request for preauthorization must be received by the reviewer designated by the Director, OCHAMPUS prior to the planned admission. In general, the decision regarding preauthorization shall be made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. In the case of an authorization issued after an admission resulting from approval of a request made prior to the admission, the effective date of the certification shall be the date of the receipt of the request. However, if the request on which the approved authorization is based was made after the admission (and the case was not an emergency admission), the effective date of the authorization shall be the date of approval.

(5) Authorization prior to admission is not required in the case of a psychiatric emergency requiring an inpatient acute level of care, but authorization for a continuation of services must be obtained promptly. Admissions resulting from a bona fide psychiatric emergency should be reported within 24 hours of the admission or the next business day after the admission, but must be reported to

the Director, OCHAMPUS or a designee, within 72 hours of the admission. In the case of an emergency admission authorization resulting from approval of a request made within 72 hours of the admission, the effective date of the authorization shall be the date of the admission. However, if it is determined that the case was not a bona fide psychiatric emergency admission (but the admission can be authorized as medically or psychologically necessary), the effective date of the authorization shall be the date of the receipt of the request.

d. Concurrent review. Concurrent review of the necessity for continued stay will be conducted. The criteria for concurrent review shall be those set forth in paragraph B.6.a. of this chapter. In applying those criteria in the context of concurrent review, special emphasis is placed on evaluating the progress being made in the active clinical treatment being provided and on developing/refining appropriate discharge plans. In general, the decision regarding concurrent review shall be made within one business day of the review, and shall be followed with written confirmation.

7. Emergency inpatient hospital services. In the case of a medical emergency, benefits can be extended for medically necessary inpatient services and supplies provided to a beneficiary by a hospital, including hospitals that do not meet CHAMPUS standards or comply with the provisions of title VI of the Civil Rights Act (reference (z)), or satisfy other conditions herein set forth. In a medical emergency, medically necessary inpatient services and supplies are those that are necessary to prevent the death or serious impairment of the health of the patient, and that, because of the threat to the life or health of the patient, necessitate, the use of the most accessible hospital available and equipped to furnish such services. The availability of benefits depends upon the following three separate findings and continues only as long as the emergency exists, as determined by medical review. If the case qualified as an emergency at the time of admission to an unauthorized institutional provider and the emergency subsequently is determined no longer to exist, benefits will be extended up through the date of notice to the beneficiary and provider that CHAMPUS benefits no longer are payable in that hospital.

a. Existence of medical emergency. A determination that a medical emergency existed with regard to the patient's condition;

b. Immediate admission required. A determination that the condition causing the medical emergency required immediate admission to a hospital to provide the emergency care; and

c. Closest hospital utilized. A determination that diagnosis or treatment was received at the most accessible (closest) hospital available and equipped to furnish the medically necessary care.

8. RTC day limit.

a. With respect to mental health services provided on or after October 1, 1991, benefits for residential treatment are generally limited to 150 days in a fiscal year or 150 days in an admission (not including days of care prior to October 1, 1991). The RTC benefit limit is separate from the benefit limit for acute inpatient mental health care.

b. Waiver of the RTC day limit.

(1) There is a statutory presumption against the appropriateness of residential treatment services in excess of the 150 day limit. However, the Director, OCHAMPUS, (or designee) may in special cases, after considering the opinion of the peer review designated by the Director (involving a health professional who is not a federal employee) confirming that applicable criteria have been met, waive the RTC benefit limit in paragraph B.8.a. of this chapter and authorize payment for care beyond that limit.

(2) The criteria for waiver shall be those set forth in paragraph B.4.g. of this chapter. In applying those criteria to the context of waiver request reviews, special emphasis is placed on assuring that the record documents that:

(a) Active treatment has taken place for the past 150 days and substantial progress has been made according to the plan of treatment.

(b) The progress made is insufficient, due to the complexity of the illness, for the patient to be discharged to a less intensive level of care.

(c) Specific evidence is presented to explain the factors which interfered with treatment progress during the 150 days of RTC care.

(d) The waiver request includes specific time frames and a specific plan of treatment which will lead to discharge.

(3) Where family or social issues complicate transfer to a lower level of intensity, the RTC is responsible for determining and arranging the supportive and adjunctive resources required to permit appropriate transfer. If the RTC fails adequately to meet this responsibility, the existence of such family or social issues shall be an inadequate basis for a waiver of the benefit limit.

(4) It is the responsibility of the patient's attending clinician to establish, through actual documentation from the medical record and other sources, that the conditions for waiver exist.

c. RTC day limits do not apply to services provided under the Program for the Handicapped (Chapter 5 of this Regulation) or services provided as partial hospitalization care.

9. Acute care day limits.

a. With respect to mental health care services provided on or after October 1, 1991, payment for inpatient acute hospital care is, in general, statutorily limited as follows:

(1) Adults, aged 19 and over - 30 days in a fiscal year or 30 days in an admission (excluding days provided prior to October 1, 1991).

(2) Children and adolescents, aged 18 and under - 45 days in a fiscal year or 45 days in an admission (excluding days provided prior to October 1, 1991).

b. It is the patient's age at the time of admission that determines the number of days available.

c. Waiver of the acute care day limits.

(1) There is a statutory presumption against the appropriateness of inpatient acute services in excess of the day limits set forth in paragraph B.9.a. of this chapter. However, the Director, OCHAMPUS (or designee) may in special cases, after considering the opinion of the peer review designated by the Director (involving a health professional who is not a federal employee) confirming that applicable criteria have been met, waive the acute inpatient limits described in paragraph B.9.a. of this chapter and authorize payment for care beyond those limits.

(2) The criteria for waiver of the acute inpatient limit shall be those set forth in paragraph B.6.a. of this chapter. In applying those criteria in the context of waiver request review, special emphasis is placed on determining whether additional days of acute inpatient mental health care are medically/psychologically necessary to complete necessary elements of the treatment plan prior to implementing appropriate discharge planning. A waiver may also be granted in cases in which a patient exhibits well-documented new symptoms, maladaptive behavior, or medical complications which have appeared in the inpatient setting requiring a significant revision to the treatment plan.

(3) The clinician responsible for the patient's care is responsible for documenting that a waiver criterion has been met and must establish an estimated length of stay beyond the date of the inpatient limit. There must be evidence of a coherent and specific plan for assessment, intervention and reassessment that reasonably can be accomplished within the time frame of the additional days of coverage requested under the waiver provision.

(4) For patients in care at the time the inpatient limit is reached, a waiver must be requested prior to the limit. For patients being readmitted after having received 30 or 45 days in the fiscal year, the waiver review will be conducted at the time of the preadmission authorization.

d. Acute care day limits do not apply to services provided under the Program for the Handicapped (Chapter 5 of this Regulation) or services provided as partial hospitalization care.

10. Psychiatric partial hospitalization services.

a. In general. Partial hospitalization services are those services furnished by a CHAMPUS-authorized partial hospitalization program and authorized mental health providers for the active treatment of a mental disorder. All services must follow a medical model and vest patient care under the general direction of a licensed psychiatrist employed by the partial hospitalization center to ensure medication and physical needs of all the patients are considered. The primary or attending provider must be a CHAMPUS authorized mental health provider, operating within the scope of his/her license. These categories include physicians, clinical psychologists, certified psychiatric nurse specialists, clinical social workers,

marriage and family counselors, pastoral counselors and mental health counselors. Partial hospitalization services are covered as a basic program benefit only if they are provided in accordance with this paragraph B.10. of this chapter.

b. Criteria for determining medical or psychological necessity of psychiatric partial hospitalization services. Psychiatric partial hospitalization services will be considered necessary only if all of the following conditions are present:

(1) The patient is suffering significant impairment from a mental disorder (as defined in Chapter 2) which interferes with age appropriate functioning.

(2) The patient is unable to maintain himself or herself in the community, with appropriate support, at a sufficient level of functioning to permit an adequate course of therapy exclusively on an outpatient basis (but is able, with appropriate support, to maintain a basic level of functioning to permit partial hospitalization services and presents no substantial imminent risk of harm to self or others).

(3) The patient is in need of crisis stabilization, treatment of partially stabilized mental health disorders, or services as a transition from an inpatient program.

(4) The admission into the partial hospitalization program is based on the development of an individualized diagnosis and treatment plan expected to be effective for that patient and permit treatment at a less intensive level.

c. Preauthorization and concurrent review requirements. All preadmission authorization and concurrent review requirements and procedures applicable to acute mental health inpatient hospital care in paragraphs A.12. and B. of this chapter are applicable to the partial hospitalization program, except that the criteria for considering medical or psychological necessity shall be those set forth in paragraph B.10.b. of this chapter, and no emergency admissions will be recognized.

d. Institutional benefits limited to 60 days. Benefits for institutional services for partial hospitalization are limited to 60 treatment days (whether a full day or partial day program) in a fiscal year or in an admission. This limit may be extended by waiver.

e. Waiver of the 60-day partial hospitalization program limit. The Director, OCHAMPUS (or designee) may, in special cases, waive the 60-day partial hospitalization benefit and authorize payment for care beyond the 60-day limit.

(1) The criteria for waiver are set forth in paragraph B.10.b. of this chapter. In applying these criteria in the context of waiver request review, special emphasis is placed on determining whether additional days of partial hospitalization are medically/psychologically necessary to complete essential elements of the treatment plan prior to discharge. Consideration is also given in cases in which a patient exhibits well-documented new symptoms or maladaptive behaviors which have appeared in the partial hospitalization setting requiring significant revisions to the treatment plan.

(2) The clinician responsible for the patient's care is responsible for documenting the need for additional days and must establish an estimated length of stay beyond the date of the 60-day limit. There must be evidence of a coherent and specific plan for assessment, intervention and reassessment that reasonably can be accomplished within the time frame of the additional days of coverage requested under the waiver provisions.

(3) For patients in care at the time the partial hospitalization program limit is reached, a waiver must be requested prior to the limit. For patients being readmitted after having received 60 days in the fiscal year, the waiver review will be conducted at the time of the preadmission authorization.

f. Services and supplies. The following services and supplies are included in the per diem rate approved for an authorized partial hospitalization program:

(1) Board. Includes use of the partial hospital facilities such as food service, supervised therapeutically constructed recreational and social activities, and other general services as considered appropriate by the Director, OCHAMPUS, or a designee.

(2) Patient assessment. Includes the assessment of each individual accepted by the facility, and must, at a minimum, consist of a physical examination; psychiatric examination; psychological assessment; assessment of physiological, biological and cognitive processes; developmental assessment; family history and assessment; social history and assessment; educational or vocational history and assessment; environmental assessment; and recreational/activities assessment. Assessments conducted within 30 days prior to admission to a partial program may be used if approved and deemed adequate to permit treatment planning by the partial hospital program.

(3) Psychological testing.

(4) Treatment services. All services, supplies, equipment and space necessary to fulfill the requirements of each patient's individualized diagnosis and treatment plan (with the exception of the five psychotherapy sessions per week which may be allowed separately for individual or family psychotherapy based upon the provisions of B.10.g. of this chapter.) All mental health services must be provided by a CHAMPUS authorized individual professional provider of mental health services. [Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate but the individual must work under the clinical supervision of a fully qualified mental health provider employed by the PHP.]

g. Social services required. The facility must provide an active social services component which assures the patient appropriate living arrangements after treatment hours, transportation to and from the facility, arrangement of community based support services, referral of suspected child abuse to the appropriate state agencies, and effective after care arrangements, at a minimum.

h. Educational services required. Programs treating children and adolescents must ensure the provision of a state certified educational component which assures that patients do not fall behind in educational placement while receiving partial hospital treatment. CHAMPUS will not fund the cost of educational services separately from the per diem rate. The hours devoted to education do not count toward the therapeutic half or full day program.

i. Family therapy required. The facility must ensure the provision of an active family therapy treatment component which assures that each patient and family participate at least weekly in family therapy provided by the institution and rendered by a CHAMPUS authorized individual professional provider of mental health services. There is no acceptable substitute for family therapy. An exception to this requirement may be granted on a case-by-case basis by the Director, OCHAMPUS, or designee, only if family therapy is clinically contraindicated.

j. Professional mental health benefits limited. Professional mental health benefits are limited to a maximum of one session (60 minutes individual, 90 minutes family) per authorized treatment day not to exceed five sessions in any calendar week. These may be billed separately from the partial hospitalization per diem rate only when rendered by an attending, CHAMPUS-authorized mental health professional who is not an employee of, or under contract with, the partial hospitalization program for purposes of providing clinical patient care.

k. Non-mental health related medical services. Separate billing will be allowed for otherwise covered, non-mental health related medical services.

C. PROFESSIONAL SERVICES BENEFIT

1. General. Benefits may be extended for those covered services described in this section C., that are provided in accordance with good medical practice and established standards of quality by physicians or other authorized individual professional providers, as set forth in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, exceptions, limitations, or exclusion as may be otherwise set forth in this or other chapters of this Regulation. Except as otherwise specifically authorized, to be considered for benefits under this section C., the described services must be rendered by a physician, or prescribed, ordered, and referred medically by a physician to other authorized individual professional providers. Further, except under specifically defined circumstances, there should be an attending physician in any episode of care. (For example, certain services of a clinical psychologist are exempt from this requirement. For these exceptions, refer to Chapter 6.)

a. Billing practices. To be considered for benefits under this section C., covered professional services must be performed personally by the physician or other authorized individual professional provider, who is other than a salaried or contractual staff member of a hospital or other authorized institution, and who ordinarily and customarily bills on a fee-for-service basis for professional services rendered. Such billings must be itemized fully and sufficiently descriptive to permit CHAMPUS to determine

whether benefits are authorized by this Regulation. See paragraph C.3.m. of this Chapter for the requirements regarding the special circumstances for teaching physicians. For continuing professional care, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor, or directly by the physician or other authorized individual professional provider on behalf of a beneficiary (refer to Chapter 7 of this Regulation).

b. Services must be related. Covered professional services must be rendered in connection with and directly related to a covered diagnosis or definitive set of symptoms requiring medically necessary treatment.

2. Covered services of physicians and other authorized individual professional providers

a. Surgery. Surgery means operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and the following procedures:

- Bronchoscopy
- Laryngoscopy
- Thoracoscopy
- Catheterization of the heart
- Arteriograph thoracic lumbar
- Esophagoscopy
- Gastrosocopy
- Proctoscopy
- Sigmoidoscopy
- Peritoneoscopy
- Cystoscopy
- Colonoscopy
- Upper G.I. panendoscopy
- Encephalograph
- Myelography
- Discography
- Visualization of intracranial aneurysm by intracarotid
injection of dye, with exposure of carotid artery,
unilateral
- Ventriculography
- Insufflation of uterus and fallopian tubes for determination
of tubal patency (Rubin's test of injection of
radiopaque medium or for dilation)
- Introduction of opaque media into the cranial arterial
system, preliminary to cerebral arteriography, or into
vertebral and subclavian systems
- Intraspinal introduction of air preliminary to
pneumoencephalography
- Intraspinal introduction of opaque media preliminary to
myelography
- Intraventricular introduction of air preliminary to
ventriculography

NOTE: The Director, OCHAMPUS, or a designee, shall determine such additional procedures that may fall within the intent of this definition of "surgery."

- b. Surgical assistance.
- c. Inpatient medical services.
- d. Outpatient medical services.
- e. Psychiatric services.
- f. Consultation services.
- g. Anesthesia services.
- h. Radiation therapy services.
- i. X-ray services.
- j. Laboratory and pathological services.
- k. Physical medicine services or physiatry services.
- l. Maternity care.
- m. Well-baby care.
- n. Other medical care. Other medical care includes, but is not limited to, hemodialysis, inhalation therapy, shock therapy, and chemotherapy. The Director, OCHAMPUS, or a designee, shall determine those additional medical services for which benefits may be extended under this paragraph.

NOTE: A separate professional charge for the oral administration of approved antineoplastic drugs is not covered.

- o. Private duty (special) nursing services.
- p. Routine eye examinations. Coverage for routine eye examinations is limited to dependents of active duty members, to one examination per calendar year per person, and to services rendered on or after October 1, 1984.

3. Extent of professional benefits

a. Multiple surgery. In cases of multiple surgical procedures performed during the same operative session, benefits shall be extended as follows:

(1) One hundred (100) percent of the CHAMPUS-determined allowable charge for the major surgical procedure (the procedure for which the greatest amount is payable under the applicable reimbursement method); and

(2) Fifty (50) percent of the CHAMPUS-determined allowable charge for each of the other surgical procedures.

(3) Except that:

(a) If the multiple surgical procedures involve the fingers or toes, benefits for the first surgical procedure shall be at one hundred (100) percent of the CHAMPUS-determined allowable charge; the second procedure at fifty (50) percent; and the third and subsequent procedures at twenty-five (25) percent.

(b) If the multiple surgical procedures include an incidental procedure, no benefits shall be allowed for the incidental procedure.

(c) If the multiple surgical procedures involve specific procedures identified by the Director, OCHAMPUS, benefits shall be limited as set forth in CHAMPUS instructions.

b. Different types of inpatient care, concurrent. If a beneficiary receives inpatient medical care during the same admission in which he or she also receives surgical care or maternity care, the beneficiary shall be entitled to the greater of the CHAMPUS-determined allowable charge for either the inpatient medical care or surgical or maternity care received, as the case may be, but not both; except that the provisions of this paragraph C.3.b. shall not apply if such inpatient medical care is for a diagnosed condition requiring inpatient medical care not related to the condition for which surgical care or maternity care is received, and is received from a physician other than the one rendering the surgical care or maternity care.

NOTE: This provision is not meant to imply that when extra time and special effort are required due to postsurgical or postdelivery complications, the attending physician may not request special consideration for a higher than usual charge.

c. Need for surgical assistance. Surgical assistance is payable only when the complexity of the procedure warrants a surgical assistant (other than the surgical nurse or other such operating room personnel), subject to utilization review. In order for benefits to be extended for surgical assistance service, the primary surgeon may be required to certify in writing to the nonavailability of a qualified intern, resident, or other house physician. When a claim is received for a surgical assistant involving the following circumstances, special review is required to ascertain whether the surgical assistance service meets the medical necessity and other requirements of this section C.

(1) If the surgical assistance occurred in a hospital that has a residency program in a specialty appropriate to the surgery;

(2) If the surgery was performed by a team of surgeons;

(3) If there were multiple surgical assistants; or

(4) If the surgical assistant was a partner of or from the same group of practicing surgeons as the attending surgeon.

d. Aftercare following surgery. Except for those diagnostic procedures classified as surgery in this section C., and injection and needling procedures involving the joints, the benefit payments made for surgery (regardless of the setting in which it is rendered) include normal aftercare, whether the aftercare is billed for by the physician or other authorized individual professional provider on a global, all-inclusive basis, or billed for separately.

e. Cast and sutures, removal. The benefit payments made for the application of a cast or of sutures normally covers the postoperative care including the removal of the cast or sutures. When the application is made in one geographical location and the removal of the cast or sutures must be done in another geographical location, a separate benefit payment may be provided for the removal. The intent of this provision is to provide a separate benefit only when it is impracticable for the beneficiary to use the services of the provider that applied the cast originally. Benefits are not available for the services of a second provider if those services reasonably could have been rendered by the individual professional provider who applied the cast or sutures initially.

f. Inpatient care, concurrent. Concurrent inpatient care by more than one individual professional provider is covered if required because of the severity and complexity of the beneficiary's condition or because the beneficiary has multiple conditions that require treatment by providers of different specialties. Any claim for concurrent care must be reviewed before extending benefits in order to ascertain the condition of the beneficiary at the time the concurrent care was rendered. In the absence of such determination, benefits are payable only for inpatient care rendered by one attending physician or other authorized individual professional provider.

g. Consultants who become the attending surgeon. A consultation performed within 3 days of surgery by the attending physician is considered a preoperative examination. Preoperative examinations are an integral part of the surgery and a separate benefit is not payable for the consultation. If more than 3 days elapse between the consultation and surgery (performed by the same physician), benefits may be extended for the consultation, subject to review.

h. Anesthesia administered by the attending physician. A separate benefit is not payable for anesthesia administered by the attending physician (surgeon or obstetrician) or dentist, or by the surgical, obstetrical, or dental assistant.

i. Treatment of mental disorders. CHAMPUS benefits for the treatment of mental disorders are payable for beneficiaries who are outpatients or inpatients of CHAMPUS-authorized general or psychiatric hospitals, KTCs, or specialized treatment facilities, as authorized by the Director, OCHAMPUS, or a designee. All such

services are subject to review for medical or psychological necessity and for quality of care. The Director, OCHAMPUS, reserves the right to require preauthorization of mental health services. Preauthorization may be conducted by the Director, OCHAMPUS, or a designee. In order to qualify for CHAMPUS mental health benefits, the patient must be diagnosed by a CHAMPUS-authorized licensed, qualified mental health professional to be suffering from a mental disorder, according to the criteria listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Benefits are limited for certain mental disorders, such as specific developmental disorders. No benefits are payable for "Conditions Not Attributable to a Mental Disorder," or V codes. In order for treatment of a mental disorder to be medically or psychologically necessary, the patient must, as a result of a diagnosed mental disorder, be experiencing both physical or psychological distress and an impairment in his or her ability to function in appropriate occupational, educational or social roles. It is generally the degree to which the patient's ability to function is impaired that determines the level of care (if any) required to treat the patient's condition.

(1) Covered diagnostic and therapeutic services. Subject to the requirements and limitations stated, CHAMPUS benefits are payable for the following services when rendered in the diagnosis or treatment of a covered mental disorder by a CHAMPUS-authorized, qualified mental health provider practicing within the scope of his or her license. Qualified mental health providers are: psychiatrists or other physicians; clinical psychologists, certified psychiatric nurse specialists or clinical social workers; and certified marriage and family therapists, pastoral, and mental health counselors, under a physician's supervision. No payment will be made for any service listed in this subparagraph C.3.i.(1) rendered by an individual who does not meet the criteria of Chapter 6 of this Regulation for his or her respective profession, regardless of whether the provider is an independent professional provider or an employee of an authorized professional or institutional provider.

(a) Individual psychotherapy, adult or child. A covered individual psychotherapy session is no more than 60 minutes in length. An individual psychotherapy session of up to 120 minutes in length is payable for crisis intervention.

(b) Group psychotherapy. A covered group psychotherapy session is no more than 90 minutes in length.

(c) Family or conjoint psychotherapy. A covered family or conjoint psychotherapy session is no more than 90 minutes in length. A family or conjoint psychotherapy session of up to 180 minutes in length is payable for crisis intervention.

(d) Psychoanalysis. Psychoanalysis is covered when provided by a graduate or candidate of a psychoanalytic training institution recognized by the American Psychological Association or the American Psychiatric Association and when preauthorized by the Director, OCHAMPUS, or a designee.

(e) Psychological testing and assessment. Psychological testing and assessment is generally limited to six hours of testing in a fiscal year when medically or psychologically necessary and in conjunction with otherwise covered psychotherapy. Testing or assessment in excess of these limits requires review for medical necessity. Benefits will not be provided for the Reitan-Indiana battery when administered to a patient under age five, for self-administered tests administered to patients under age 13, or for psychological testing and assessment as part of an assessment for academic placement.

(f) Administration of psychotropic drugs. When prescribed by an authorized provider qualified by licensure to prescribe drugs.

(g) Electroconvulsive treatment. When provided in accordance with guidelines issued by the Director, OCHAMPUS.

(h) Collateral visits. Covered collateral visits are those that are medically or psychologically necessary for the treatment of the patient and, as such, are considered as a psychotherapy session for purposes of subparagraph C.3.i.(2) of this chapter.

(2) Limitations and review requirements

(a) Outpatient psychotherapy. Outpatient psychotherapy generally is limited to a maximum of two psychotherapy sessions per week, in any combination of individual, family, conjoint, collateral, or group sessions. Before benefits can be extended for more than two outpatient psychotherapy sessions per week, professional review of the medical or psychological necessity for and appropriateness of the more intensive therapy is required.

(b) Inpatient psychotherapy. Coverage of inpatient psychotherapy is based on the medical or psychological necessity for the services identified in the patient's treatment plan. As a general rule, up to five psychotherapy sessions per week are considered appropriate. Additional sessions per week or more than one type of psychotherapy session performed on the same day (for example, an individual psychotherapy session and a family psychotherapy session on the same day) could be considered for coverage, depending on the medical or psychological necessity for the services. Benefits for inpatient psychotherapy will end automatically when authorization has been granted for the maximum number of inpatient mental health days in accordance with the limits as described in this Chapter 4, unless additional coverage is granted by the Director, OCHAMPUS or a designee.

(3) Covered ancillary therapies. Includes art, music, dance, occupational, and other ancillary therapies, when included by the attending provider in an approved inpatient, residential treatment plan and under the clinical supervision of a licensed doctoral level mental health professional. These ancillary therapies are not separately reimbursed professional services but are included within the institutional reimbursement.

(4) Review of claims for treatment of mental disorder. The Director, OCHAMPUS, shall establish and maintain procedures for review, including professional review, of the services provided for the treatment of mental disorders.

j. Physical and occupational therapy

(1) Physical therapy. To be covered, physical therapy must be related to a covered medical condition. If performed by other than a physician, a physician (or other authorized individual professional provider acting within the scope of their license) shall refer the patient for treatment and supervise the physical therapy. Generally, coverage of outpatient physical therapy is limited to a 60-day period, at up to two physical therapy sessions per week. Physical therapy beyond this length or frequency requires documentation of the medical necessity for the therapy and the anticipated results of the therapy. General exercise programs are not covered, even if recommended by a physician and conducted by qualified personnel. Passive exercises and range of motion exercises are not covered except when prescribed as an integral part of a comprehensive program of physical therapy.

(2) Occupational therapy. To be covered, occupational therapy must be related to a covered medical condition and must be directed to assisting the patient to overcome or compensate for disability resulting from illness, injury, or the effects of treatment of a covered condition. If performed by other than a physician, a physician shall prescribe the treatment and a physician shall supervise the occupational therapy. The occupational therapist providing the therapy shall be an employee of a CHAMPUS-authorized institutional provider and the services must be rendered in connection with CHAMPUS authorized care. Only those occupational therapy services that are rendered as part of an organized inpatient or outpatient rehabilitation program are covered. Occupational therapists are not considered CHAMPUS-authorized providers in their own right and may not submit bills on a fee-for-service basis. The employing institutional provider shall bill for the services of the occupational therapist.

k. Well-baby care. Benefits routinely are payable for well-baby care from birth up to the child's second birthday.

(1) The following services are payable when rendered as a part of a specific well-baby care program and when rendered by the attending pediatrician, family physician, or a pediatric nurse practitioner:

- (a) Newborn examination, PKU tests, and newborn circumcision.
- (b) History, physical examination, discussion, and counseling.
- (c) Vision, hearing, and dental screening.
- (d) Developmental appraisal.
- (e) Immunization (that is, DPT, polio, measles, mumps, and rubella).
- (f) Tuberculin test, hematocrit or Hgb., and urinalysis.

(2) Additional services or visits required because of specific findings or because of the particular circumstance of the individual case are covered if medically necessary and otherwise authorized for benefits under CHAMPUS.

1. Private duty (special) nursing. Benefits are available for the skilled nursing services rendered by a private duty (special) nurse to a beneficiary requiring intensive skilled nursing care that can only be provided with the technical proficiency and scientific skills of an R.N. The specific skilled nursing services being rendered are controlling, not the condition of the patient or the professional status of the private duty (special) nurse rendering the services.

(1) Inpatient private duty (special) nursing services are limited to those rendered to an inpatient in a hospital that does not have an ICU. In addition, under specified circumstances, private duty (special) nursing in the home setting also is covered.

(2) The private duty (special) nursing care must be ordered and certified to be medically necessary by the attending physician.

(3) The skilled nursing care must be rendered by a private duty (special) nurse who is neither a member of the immediate family nor is a member of the beneficiary's household.

(4) Private duty (special) nursing care does not, except incidentally, include providing services that provide or support primarily the essentials of daily living or acting as a companion or sitter.

(5) If the private duty (special) nursing care services being performed are primarily those that could be rendered by the average adult with minimal instruction or supervision, the services would not qualify as covered private duty (special) nursing services, regardless of whether performed by an R.N., regardless of whether or not ordered and certified to by the attending physician, and regardless of the condition of the patient.

(6) In order for such services to be considered for benefits, a private duty (special) nurse is required to maintain detailed daily nursing notes, whether the case involves inpatient nursing service or nursing services rendered in the home setting.

(7) Claims for continuing private duty (special) nursing care shall be submitted at least every 30 days. Each claim will be reviewed and the nursing care evaluated whether it continues to be appropriate and eligible for benefits.

(8) In most situations involving private duty (special) nursing care rendered in the home setting, benefits will be available only for a portion of the care, that is, providing benefits only for that time actually required to perform medically necessary skilled nursing services. If full-time private duty (special) nursing services are engaged, usually for convenience or to provide personal services to the patient, CHAMPUS benefits are payable only for that portion of the day during which skilled nursing services are rendered, but in no event is less than 1 hour of nursing care payable in any 24-hour period during which skilled nursing services are determined to have been rendered. Such situations often are

better accommodated through the use of visiting nurses. This allows the personal services that are not coverable by CHAMPUS to be obtained at lesser cost from other than an R.N. Skilled nursing services provided by visiting nurses are covered under CHAMPUS.

NOTE: When the services of an R.N. are not available, benefits may be extended for the otherwise covered services of a L.P.N. or L.V.N.

m. Physicians in a teaching setting.

(1) Teaching Physicians.

(a) General. The services of teaching physicians may be reimbursed on an allowable charge basis only when the teaching physician has established an attending physician relationship between the teaching physician and the services (e.g., services rendered as a consultant, assistant surgeon, etc.). Attending physician services may include both direct patient care services or direct supervision of care provided by a physician in training. In order to be considered an attending physician, the teaching physician must:

1 Review the patient's history and the record of examinations and tests in the institution, and make frequent reviews of the patient's progress; and

2 Personally examine the patient; and

3 Confirm or revise the diagnosis and determine the course of treatment to be followed; and

4 Either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by physicians in training and that the care meets a proper quality level; and

5 Be present and ready to perform any service performed by an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; and

6 Be personally responsible for the patient's care, at least throughout the period of hospitalization.

(b) Direct supervision by an attending physician of care provided by physicians in training. Payment on the basis of allowable charges may be made for the professional services rendered to a beneficiary by his/her attending physician when the attending physician provides personal and identifiable direction to physicians in training who are participating in the care of the patient. It is not necessary that the attending physician be personally present for all services, but the attending physician must be on the provider's premises and available to provide immediate personal assistance and direction if needed.

(c) Individual, personal services. A teaching physician may be reimbursed on an allowable charge basis for any individual, identifiable service rendered to a CHAMPUS beneficiary, so long as the service is a covered service and is normally reimbursed separately, and so long as the patient records substantiate the service.

(d) Who may bill. The services of a teaching physician must be billed by the institutional provider when the physician is employed by the provider or a related entity or under a contract which provides for payment to the physician by the provider or a related entity. Where the teaching physician has no relationship with the provider (except for standard physician privileges to admit patients) and generally treats patients on a fee-for-service basis in the private sector, the teaching physician may submit claims under his/her own provider number.

(2) Physicians in training. Physicians in training in an approved teaching program are considered to be "students" and may not be reimbursed directly by CHAMPUS for services rendered to a beneficiary when their services are provided as part of their employment (either salaried or contractual) by a hospital or other institutional provider. Services of physicians in training may be reimbursed on an allowable charge basis only if:

(a) The physician in training is fully licensed to practice medicine by the state in which the services are performed, and

(b) The services are rendered outside the scope and requirements of the approved training program to which the physician in training is assigned.

D. OTHER BENEFITS

1. General. Benefits may be extended for the allowable charge of those other covered services and supplies described in this section D., which are provided in accordance with good medical practice and established standards of quality by those other authorized providers described in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, limitations, or exclusions as otherwise may be set forth in this or other chapters of this Regulation. To be considered for benefits under this section D., the described services or supplies must be prescribed and ordered by a physician. Other authorized individual professional providers acting within their scope of licensure may also prescribe and order these services and supplies unless otherwise specified in this section D. For example, durable medical equipment and cardiorespiratory monitors can only be ordered by a physician.

2. Billing practices. To be considered for benefits under this Section D., covered services and supplies must be provided and billed for by an authorized provider as set forth in Chapter 6 of this Regulation. Such billing must be itemized fully and described sufficiently, even when CHAMPUS payment is determined under the CHAMPUS DRG-based payment system, so that CHAMPUS can determine whether benefits are authorized by this Regulation. Except for claims subject to the

CHAMPUS DRG-based payment system, whenever continuing charges are involved, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days (monthly) either by the beneficiary or sponsor or directly by the provider. For claims subject to the CHAMPUS DRG-based payment system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

3. Other covered services and supplies

a. Blood. If whole blood or plasma (or its derivatives) are provided and billed for by an authorized institution in connection with covered treatment, benefits are extended as set forth in section B. of this chapter. If blood is billed for directly to a beneficiary, benefits may be extended under this section D. in the same manner as a medical supply.

b. Durable medical equipment

(1) Scope of benefit. Subject to the exceptions in paragraphs (2) and (3) below, only durable medical equipment (DME) which is ordered by a physician for the specific use of the beneficiary, and which complies with the definition of "Durable Medical Equipment" in Chapter 2 of this Regulation, and which is not otherwise excluded by this Regulation qualifies as a Basic Program benefit.

(2) Cardiorespiratory monitor exception.

(a) When prescribed by a physician who is otherwise eligible as a CHAMPUS individual professional provider, or who is on active duty with a United States Uniformed Service, an electronic cardiorespiratory monitor, including technical support necessary for the proper use of the monitor, may be cost-shared as durable medical equipment when supervised by the prescribing physician for in-home use by:

1 An infant beneficiary who has had an apparent life-threatening event, as defined in guidelines issued by the Director, OCHAMPUS, or a designee, or,

2 An infant beneficiary who is a subsequent or multiple birth biological sibling of a victim of sudden infant death syndrome (SIDS), or,

3 An infant beneficiary whose birth weight was 1,500 grams or less, or,

4 An infant beneficiary who is a pre-term infant with pathologic apnea, as defined in guidelines issued by the Director, OCHAMPUS, or a designee, or,

5 Any beneficiary who has a condition or suspected condition designated in guidelines issued by the Director, OCHAMPUS, or designee, for which the in-home use of the cardiorespiratory monitor otherwise meets Basic Program requirements.

(b) The following types of services and items may be cost-shared when provided in conjunction with an otherwise authorized cardiorespiratory monitor:

1 Trend-event recorder, including technical support necessary for the proper use of the recorder.

2 Analysis of recorded physiological data associated with monitor alarms.

3 Professional visits for services otherwise authorized by this Regulation, and for family training on how to respond to an apparent life-threatening event.

4 Diagnostic testing otherwise authorized by this Regulation.

(3) Basic mobility equipment exception. A wheelchair, or a CHAMPUS-approved alternative, which is medically necessary to provide basic mobility, including reasonable additional cost for medically necessary modifications to accommodate a particular disability, may be cost-shared as durable medical equipment.

(4) Exclusions. DME which is otherwise qualified as a benefit is excluded as a benefit under the following circumstances:

(a) DME for a beneficiary who is a patient in a type of facility that ordinarily provides the same type of DME item to its patients at no additional charge in the usual course of providing its services.

(b) DME which is available to the beneficiary from a Uniformed Services Medical Treatment Facility.

(c) DME with deluxe, luxury, or immaterial features which increase the cost of the item to the government relative to similar item without those features.

(5) Basis for reimbursement. The cost of DME may be shared by the CHAMPUS based upon the price which is most advantageous to the government taking into consideration the anticipated duration of the medically necessary need for the equipment and current price information for the type of item. The cost analysis must include a comparison of the total price of the item as a monthly rental charge, a lease-purchase price, and a lump-sum purchase price and a provision for the time value of money at the rate determined by the U.S. Department of the Treasury.

c. Medical supplies and dressings (consumables). Medical supplies and dressings (consumables) are those that do not withstand prolonged, repeated use. Such items must be related directly to an appropriate and verified covered medical condition of the specific beneficiary for whom the item was purchased and obtained from a medical supply company, a pharmacy, or authorized institutional provider. Examples of covered medical supplies and dressings are disposable syringes for a known diabetic, colostomy sets, irrigation sets, and elastic bandages. An external surgical garment specifically designed for use following a mastectomy is considered a medical supply item.

NOTE: Generally, the allowable charge of a medical supply item will be under \$100. Any item over this amount must be reviewed to determine whether it would not qualify as a DME item. If it is, in fact, a medical supply item and does not represent an excessive charge, it can be considered for benefits under paragraph D.3.c., above.

d. Oxygen. Oxygen and equipment for its administration are covered. Benefits are limited to providing a tank unit at one location with oxygen limited to a 30-day supply at any one time. Repair and adjustment of CHAMPUS-purchased oxygen equipment also is covered.

e. Ambulance. Civilian ambulance service to, from, and between hospitals is covered when medically necessary in connection with otherwise covered services and supplies and a covered medical condition. Ambulance service also is covered for transfers to a Uniformed Service Medical Treatment Facility (USMTF). For the purpose of CHAMPUS payment, ambulance service is an outpatient service (including in connection with maternity care) with the exception of otherwise covered transfers between hospitals which are cost-shared on an inpatient basis. Ambulance transfers from a hospital based emergency room to another hospital more capable of providing the required care will also be cost-shared on an inpatient basis.

NOTE: The inpatient cost-sharing provisions for ambulance transfers only apply to otherwise covered transfers between hospitals; i.e., acute care, general, and special hospitals; psychiatric hospitals; and long-term hospitals.

(1) Ambulance service is covered for emergency transfers from a beneficiary's place of residence, accident scene, or other location to a USMTF, and for transfer to a USMTF after treatment at, or admission to, a civilian hospital, if ordered by other than a representative of the USMTF.

(2) Ambulance service cannot be used instead of taxi service and is not payable when the patient's condition would have permitted use of regular private transportation; nor is it payable when transport or transfer of a patient is primarily for the purpose of having the patient nearer to home, family, friends, or personal physician. Except as described in subparagraph D.3.e.(1), above, transport must be to closest appropriate facility by the least costly means.

(3) Vehicles such as medicabs or ambicabs function primarily as public passenger conveyances transporting patients to and from their medical appointments. No actual medical care is provided to the patients in transit. These types of vehicles do not qualify for benefits for the purpose of CHAMPUS payment.

(4) Ambulance services by other than land vehicles (such as a boat or airplane) may be considered only when the pickup point is inaccessible by a land vehicle, or when great distance or other obstacles are involved in transporting the patient to the nearest hospital with appropriate facilities and the patient's medical condition warrants speedy admission or is such that transfer by other means is contraindicated.

f. Prescription drugs and medicines. Prescription drugs and medicines that by United States law require a physician's or other authorized individual professional provider's prescription (acting within the scope of their license) and that are ordered or prescribed by a physician or other authorized individual professional provider (except that insulin is covered for a known diabetic, even though a prescription may not be required for its purchase) in connection with an otherwise covered condition or treatment, including Rh immune globulin.

(1) Drugs administered by a physician or other authorized individual professional provider as an integral part of a procedure covered under sections B. or C. of this chapter (such as chemotherapy) are not covered under this subparagraph inasmuch as the benefit for the institutional services or the professional services in connection with the procedure itself also includes the drug used.

(2) CHAMPUS benefits may not be extended for drugs not approved by the U.S. Food and Drug Administration for commercial marketing. Drugs grandfathered by the Federal Food, Drug and Cosmetic Act of 1938 may be covered under CHAMPUS as if FDA approved.

g. Prosthetic devices. The purchase of prosthetic devices is limited to artificial limbs and eyes, except those items that are inserted surgically into the body as an essential and integral part of an otherwise covered surgical procedure are not excluded.

NOTE: In order for CHAMPUS benefits to be extended, any surgical implant must be approved for use in humans by the U.S. Food and Drug Administration. Devices that are approved only for investigational use in humans are not payable.

h. Orthopedic braces and appliances. The purchase of leg braces (including attached shoes), arm braces, back braces, and neck braces is covered. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes or regular shoes subsequently built up, are not covered.

E. SPECIAL BENEFIT INFORMATION

1. General. There are certain circumstances, conditions, or limitations that impact the extension of benefits and that require special emphasis and explanation. This section E. sets forth those benefits and limitations recognized to be in this category. The benefits and limitations herein described also are subject to all applicable definitions, conditions, limitations, exceptions, and exclusions as set forth in this or other chapters of this Regulation, except as otherwise may be provided specifically in this section E.

2. Abortion. The statute under which CHAMPUS operates prohibits payment for abortions with one single exception--where the life of the woman would be endangered if the fetus were carried to term. Covered abortion services are limited to medical services and supplies only. Physician certification is required attesting that the abortion was performed because the mother's life would have been endangered if the fetus were carried to term. Abortions performed for suspected or confirmed fetal abnormality (e.g., anencephalic) or for mental health reasons (e.g., threatened suicide) do not fall within the exceptions permitted within the language of the statute and are not authorized for payment under CHAMPUS.

NOTE: Covered abortion services are limited to medical services or supplies only for the single circumstance outlined above and do not include abortion counseling or referral fees. Payment is not allowed for any services involving preparation for, or normal followup to, a noncovered abortion. The Director, OCHAMPUS, or a designee, shall issue guidelines describing the policy on abortion.

3. Family planning. The scope of the CHAMPUS family planning benefit is as follows:

a. Birth control (such as contraception)

(1) Benefits provided. Benefits are available for services and supplies related to preventing conception, including the following:

(a) Surgical insertion, removal, or replacement of intrauterine devices.

(b) Measurement for, and purchase of, contraceptive diaphragms (and later remeasurement and replacement).

(c) Prescription oral contraceptives.

(d) Surgical sterilization (either male or female).

(2) Exclusions. The family planning benefit does not include the following:

(a) Prophylactics (condoms).

(b) Spermicidal foams, jellies, and sprays not requiring a prescription.

(c) Services and supplies related to noncoital reproductive technologies, including but not limited to artificial insemination (including any costs related to donors or semen banks), in-vitro fertilization and gamete intrafallopian transfer.

(d) Reversal of a surgical sterilization procedure (male or female).

b. Genetic testing. Genetic testing essentially is preventive rather than related to active medical treatment of an illness or injury. However, under the family planning benefit, genetic testing is covered when performed in certain high risk situations. For the purpose of CHAMPUS, genetic testing includes tests to detect developmental abnormalities as well as purely genetic defects.

(1) Benefits provided. Benefits may be extended for genetic testing performed on a pregnant beneficiary under the following prescribed circumstances. The tests must be appropriate to the specific risk situation and must meet one of the following criteria:

(a) The mother-to-be is 35 years old or older; or

(b) The mother- or father-to-be has had a previous child born with a congenital abnormality; or

(c) Either the mother- or father-to-be has a family history of congenital abnormalities; or

(d) The mother-to-be contracted rubella during the first trimester of the pregnancy; or

(e) Such other specific situations as may be determined by the Director, OCHAMPUS, or a designee, to fall within the intent of this paragraph E.3.b.

(2) Exclusions. It is emphasized that routine or demand genetic testing is not covered. Further, genetic testing does not include the following:

(a) Tests performed to establish paternity of a child.

(b) Tests to determine the sex of an unborn child.

4. Treatment of substance use disorders. Emergency and inpatient hospital care for complications of alcohol and drug abuse or dependency and detoxification are covered as for any other medical condition. Specific coverage for the treatment of substance use disorders includes detoxification, rehabilitation, and outpatient care provided in authorized substance use disorder rehabilitation facilities.

a. Emergency and inpatient hospital services. Emergency and inpatient hospital services are covered when medically necessary for the active medical treatment of the acute phases of substance abuse withdrawal (detoxification), for stabilization, and for treatment of medical complications of substance use disorders. Emergency and inpatient hospital services are considered medically necessary only when the patient's condition is such that the personnel and facilities of a hospital are required. Stays provided for substance use disorder rehabilitation in a hospital-based rehabilitation facility are covered, subject to the provisions of paragraph E.4.b. of this chapter. Inpatient hospital services also are subject to the provisions regarding the limit on inpatient mental health services.

b. Authorized substance use disorder treatment. Only those services provided by CHAMPUS-authorized institutional providers are covered. Such a provider must be either an authorized hospital, or an organized substance use disorder treatment program in an authorized free-standing or hospital-based substance use disorder rehabilitation facility. Covered services consist of any or all of the services listed below. A qualified mental health provider (physicians, clinical psychologists, clinical social workers, psychiatric nurse specialists) (see paragraph C.3.i. of this chapter) shall prescribe the particular level of treatment. Each CHAMPUS beneficiary is entitled to three substance use disorder treatment benefit periods in his or her lifetime, unless this limit is waived pursuant to paragraph E.4.e. of this chapter. (A benefit period begins with the first date of covered treatment and ends 365 days later, regardless of the total services actually used within the benefit period. Unused benefits cannot be carried over to subsequent benefit periods. Emergency and inpatient hospital services (as described in paragraph E.4.a. of this chapter) do not constitute substance abuse treatment for purposes of establishing the beginning of a benefit period.)

(1) Rehabilitative care. Rehabilitative care in an authorized hospital or substance use disorder rehabilitative facility, whether free-standing or hospital-based, is covered on either a residential or partial care (day or night program) basis. Coverage during a single benefit period is limited to no more than one inpatient stay (exclusive of stays classified in DRG 433) in hospitals subject to CHAMPUS DRG-based payment system or 21 days in a DRG-exempt facility for rehabilitation care, unless the limit is waived pursuant to paragraph E.4.e. of this chapter. If the patient is medically in need of chemical detoxification, but does not require the personnel or facilities of a general hospital setting, detoxification services are covered in addition to the rehabilitative care, but in a DRG-exempt facility detoxification services are limited to 7 days, unless the limit is waived pursuant to paragraph E.4.e. of this chapter. The medical necessity for the detoxification must be documented. Any detoxification services provided by the substance use disorder rehabilitation facility must be under general medical supervision.

(2) Outpatient care. Outpatient treatment provided by an approved substance use disorder rehabilitation facility, whether free-standing or hospital-based, is covered for up to 60 visits in a benefit period, unless the limit is waived pursuant to paragraph E.4.e. of this chapter.

(3) Family therapy. Family therapy provided by an approved substance use disorder rehabilitation facility, whether free-standing or hospital-based, is covered for up to 15 visits in a benefit period, unless the limit is waived pursuant to paragraph E.4.e. of this chapter.

c. Exclusions

(1) Aversion therapy. The programmed use of physical measures, such as electric shock, alcohol, or other drugs as negative reinforcement (aversion therapy) is not covered, even if recommended by a physician.

(2) Domiciliary settings. Domiciliary facilities, generally referred to as halfway or quarterway houses, are not authorized providers and charges for services provided by these facilities are not covered.

d. Confidentiality. Release of any patient identifying information, including that required to adjudicate a claim, must comply with the provisions of section 544 of the Public Health Service Act, as amended, (42 U.S.C. 290dd-3), which governs the release of medical and other information from the records of patients undergoing treatment of substance abuse. If the patient refuses to authorize the release of medical records which are, in the opinion of the Director, OCHAMPUS, or a designee, necessary to determine benefits on a claim for treatment of substance abuse the claim will be denied.

e. Waiver of benefit limits. The specific benefit limits set forth in paragraphs E.4.b. of this chapter may be waived by the Director, OCHAMPUS in special cases based on a determination that all of the following criteria are met:

(1) Active treatment has taken place during the period of the benefit limit and substantial progress has been made according to the plan of treatment.

(2) Further progress has been delayed due to the complexity of the illness.

(3) Specific evidence has been presented to explain the factors that interfered with further treatment progress during the period of the benefit limit.

(4) The waiver request includes specific time frames and a specific plan of treatment which will complete the course of treatment.

5. Organ transplants. Basic Program benefits are available for otherwise covered services or supplies in connection with an organ transplant procedure, provided such transplant procedure generally is in accordance with accepted professional medical standards and is not considered to be experimental or investigational.

a. Recipient costs. CHAMPUS benefits are payable for recipient costs when the recipient of the transplant is a beneficiary, whether or not the donor is a beneficiary.

b. Donor costs

- (1) Donor costs are payable when both the donor and recipient are CHAMPUS beneficiaries.
- (2) Donor costs are payable when the donor is a CHAMPUS beneficiary but the recipient is not.
- (3) Donor costs are payable when the donor is the sponsor and the recipient is a beneficiary. (In such an event, donor costs are paid as a part of the beneficiary and recipient costs.)
- (4) Donor costs also are payable when the donor is neither a CHAMPUS beneficiary nor a sponsor, if the recipient is a CHAMPUS beneficiary. (Again, in such an event, donor costs are paid as a part of the beneficiary and recipient costs.)

c. General limitations

- (1) If the donor is not a beneficiary, CHAMPUS benefits for donor costs are limited to those directly related to the transplant procedure itself and do not include any medical care costs related to other treatment of the donor, including complications.
- (2) In most instances, for costs related to kidney transplants, Medicare (not CHAMPUS) benefits will be applicable. If a CHAMPUS beneficiary participates as a kidney donor for a Medicare beneficiary, Medicare will pay for expenses in connection with the kidney transplant to include all reasonable preparatory, operation and postoperation recovery expenses associated with the donation (postoperative recovery expenses are limited to the actual period of recovery). (Refer to paragraph E.3.f. of Chapter 3 of this Regulation.)
- (3) Donor transportation costs are excluded whether or not the donor is a beneficiary.
- (4) When the organ transplant is performed under a study, grant, or research program, no CHAMPUS benefits are payable for either recipient or donor cost.

d. Kidney acquisition. With specific reference to acquisition costs for kidneys, each hospital that performs kidney transplants is required for Medicare purposes to develop for each year separate standard acquisition costs for kidneys obtained from live donors and kidneys obtained from cadavers. The standard acquisition cost for cadaver kidneys is compiled by dividing the total cost of cadaver kidneys acquired by the number of transplants using cadaver kidneys. The standard acquisition cost for kidneys from live donors is compiled similarly using the total acquisition cost of kidneys from live donors and the number of transplants using kidneys from live donors. All recipients of cadaver kidneys are charged the same standard cadaver kidney acquisition cost and all recipients of kidneys from live donors are charged the same standard live donor acquisition cost. The appropriate hospital standard kidney acquisition costs (live donor or cadaver) required for Medicare in every instance must be used as the acquisition cost for purposes of providing CHAMPUS benefits.

e. Liver transplants. Effective July 1, 1983, CHAMPUS benefits are payable for services and supplies related to liver transplantation under the following circumstances only:

(1) Medical indications for liver transplantation. CHAMPUS shall provide benefits for services and supplies related to liver transplantation performed for beneficiaries suffering from irreversible liver injury who have exhausted alternative medical and surgical treatments, who are approaching the terminal phase of their illness, and who are considered appropriate for liver transplantation according to guidelines adopted by the Director, OCHAMPUS.

(2) Contraindications. CHAMPUS shall not provide coverage if any of the following contraindications exist:

- (a) Active alcohol or other substance abuse;
- (b) Malignancies metastasized to or extending beyond the margins of the liver; or
- (c) Viral-induced liver disease when viremia is still present.

(3) Specific covered services. CHAMPUS shall provide coverage for the following services related to liver transplantation:

- (a) Medically necessary services to evaluate a potential candidate's suitability for liver transplantation, whether or not the patient is ultimately accepted as a candidate for transplantation;
- (b) Medically necessary pre- and post-transplant inpatient hospital and outpatient services;
- (c) Surgical services and related pre- and post-operative services of the transplant team;
- (d) Services provided by a donor organ acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center;
- (e) Medically necessary services required to maintain the viability of the donor organ following a formal declaration of brain death and after all existing legal requirements for excision of the donor organ have been met;
- (f) Blood and blood products;
- (g) Services and drugs required for immunosuppression, provided the drugs are approved by the United States Food and Drug Administration;
- (h) Services and supplies, including inpatient care, which are medically necessary to treat complications of the transplant procedure, including management of infection and rejection episodes; and

(i) Services and supplies which are medically necessary for the periodic evaluation and assessment of the successfully transplanted patient.

(4) Specific noncovered services. CHAMPUS benefits will not be paid for the following:

(a) Services and supplies for which the beneficiary has no legal obligation to pay. For example, CHAMPUS shall not reimburse expenses that are waived by the transplant center, or for which research funds are available; and

(b) Out-of-hospital living expenses and any other non-medical expenses, including transportation, of the liver transplant candidate or family members, whether pre- or post-transplant.

(5) Implementation guidelines. The Director, OCHAMPUS, shall issue such guidelines as are necessary to implement the provision of this paragraph.

f. Heart Transplantation. CHAMPUS benefits are payable for services and supplies related to heart transplantation under the following circumstances:

(1) Medical indications for heart transplantation. CHAMPUS shall provide benefits for services and supplies related to heart transplantation performed for beneficiaries with end-stage cardiac disease who have exhausted alternative medical and surgical treatments, who have a very poor prognosis as a result of poor cardiac functional status, for whom plans for long-term adherence to a disciplined medical regimen are feasible, and who are considered appropriate for heart transplantation according to guidelines adopted by the Director, OCHAMPUS. However, benefits for heart transplantation are available only if the procedure is performed in a CHAMPUS-approved heart transplantation center or meets other certification or accreditation standards recognized by the Director, OCHAMPUS. See Chapter 6, paragraph B.4.c. of this Regulation.

(2) Specific covered services. CHAMPUS shall provide coverage for the following services related to heart transplantation:

(a) Medically necessary services to evaluate a potential candidate's suitability for heart transplantation, whether or not the patient is ultimately accepted as a candidate for transplantation;

(b) Medically necessary pre- and post-transplant inpatient hospital and outpatient services;

(c) Surgical services and related pre- and post-operative services of the transplant team;

(d) Services provided by the donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center;

(e) Medically necessary services required to maintain the viability of the donor organ following a formal declaration of brain death and after all existing legal requirements for excision of the donor organ have been met;

(f) Blood and blood products;

(g) Services and drugs required for immunosuppression, provided the drugs are approved by the United States Food and Drug Administration;

(h) Services and supplies, including inpatient care, which are medically necessary to treat complications of the transplant procedure, including management of infection and rejection episodes; and

(i) Services and supplies which are medically necessary for the periodic evaluation and assessment of the successfully transplanted patient.

(3) Noncovered services. CHAMPUS benefits will not be paid for the following:

(a) Services and supplies for which the beneficiary has no legal obligation to pay; and

(b) Out-of-hospital living expenses and any other non-medical expenses, including transportation of the heart transplant candidate or family members, whether pre- or post-transplant.

(4) Implementation guidelines. The Director, OCHAMPUS, shall issue such guidelines as are necessary to implement the provisions of this paragraph.

6. Eyeglasses, spectacles, contact lenses, or other optical devices. Eyeglasses, spectacles, contact lenses, or other optical devices are excluded under the Basic Program except under very limited and specific circumstances.

a. Exception to general exclusion. Benefits for glasses and lenses may be extended only in connection with the following specified eye conditions and circumstances:

(1) Eyeglasses or lenses that perform the function of the human lens, lost as the result of intraocular surgery or ocular injury or congenital absence.

NOTE: Notwithstanding the general requirement for U.S. Food and Drug Administration approval of any surgical implant set forth in paragraph D.3.g. of this chapter, intraocular lenses are authorized under CHAMPUS if they are either approved for marketing by the FDA or are subject to an investigational device exemption.

(2) "Pinhole" glasses prescribed for use after surgery for detached retina.

(3) Lenses prescribed as "treatment" instead of surgery for the following conditions:

(a) Contact lenses used for treatment of infantile glaucoma.

(b) Corneal or scleral lenses prescribed in connection with treatment of keratoconus.

(c) Scleral lenses prescribed to retain moisture when normal tearing is not present or is inadequate.

(d) Corneal or scleral lenses prescribed to reduce a corneal irregularity other than astigmatism.

b. Limitations. The specified benefits are limited further to one set of lenses related to one of the qualifying eye conditions set forth in paragraph E.6.a., above. If there is a prescription change requiring a new set of lenses (but still related to the qualifying eye condition), benefits may be extended for a second set of lenses, subject to specific medical review.

7. Transsexualism or such other conditions as gender dysphoria. All services and supplies directly or indirectly related to transsexualism or such other conditions as gender dysphoria are excluded under CHAMPUS. This exclusion includes, but is not limited to, psychotherapy, prescription drugs, and intersex surgery that may be provided in connection with transsexualism or such other conditions as gender dysphoria. There is only one very limited exception to this general exclusion, that is, notwithstanding the definition of congenital anomaly, CHAMPUS benefits may be extended for surgery and related medically necessary services performed to correct sex gender confusion (that is, ambiguous genitalia) which has been documented to be present at birth.

8. Cosmetic, reconstructive, or plastic surgery. For the purposes of CHAMPUS, cosmetic, reconstructive, or plastic surgery is surgery that can be expected primarily to improve physical appearance or that is performed primarily for psychological purposes or that restores form, but does not correct or improve materially a bodily function.

NOTE: If a surgical procedure primarily restores function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subsection E.8.

a. Limited benefits under CHAMPUS. Benefits under the Basic Program generally are not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances, benefits for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

- (1) Correction of a congenital anomaly; or
- (2) Restoration of body form following an accidental injury; or
- (3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Reconstructive breast surgery following a medically necessary mastectomy performed for the treatment of carcinoma, severe fibrocystic disease, other nonmalignant tumors or traumatic injuries.

(5) Penile implants and testicular prostheses for conditions resulting from organic origins (i.e., trauma, radical surgery, disease process, for correction of congenital anomaly, etc.). Also penile implants for organic impotency.

NOTE: Organic impotence is defined as that which can be reasonably expected to occur following certain diseases, surgical procedures, trauma, injury, or congenital malformation. Impotence does not become organic because of psychological or psychiatric reasons.

(6) Generally, benefits are limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than December 31 of the year following the year in which the related accidental injury or surgical trauma occurred, except for authorized postmastectomy breast reconstruction for which there is no time limitation between mastectomy and reconstruction. Also, special consideration for exception will be given to cases involving children who may require a growth period.

b. General exclusions

(1) For the purposes of CHAMPUS, dental congenital anomalies such as absent tooth buds or malocclusion specifically are excluded. Also excluded are any procedures related to transsexualism or such other conditions as gender dysphoria except as provided in subsection E.7., above.

(2) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process also are excluded.

(3) Procedures performed for elective correction of minor dermatological blemishes and marks or minor anatomical anomalies also are excluded.

(4) In addition, whether or not it would otherwise qualify for benefits under paragraph E.8.a., above, the breast augmentation mammoplasty is specifically excluded.

c. Noncovered surgery, all related services and supplies excluded. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for CHAMPUS benefits, all related services and supplies are excluded, including any institutional costs.

d. Examples of noncovered cosmetic, reconstructive, or plastic surgery procedures. The following is a partial list of cosmetic, reconstructive, or plastic surgery procedures that do not qualify for benefits under CHAMPUS. This list is for example purposes only and is not to be construed as being all-inclusive.

(1) Any procedure performed for personal reasons to improve the appearance of an obvious feature or part of the body that would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures that are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties, except for those performed as a part of postmastectomy breast reconstruction as specifically authorized in subparagraph E.8.a.(4) of this chapter.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction mammoplasties (unless there is medical documentation of intractable pain, not amenable to other forms of treatment, resulting from large, pendulous breasts).

(6) Panniculectomy; body sculpture procedures.

(7) Repair of sagging eyelids (without demonstrated and medically documented significant impairment of vision).

(8) Rhinoplasties (without evidence of accidental injury occurring within the previous 6 months that resulted in significant obstruction of breathing).

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Elective correction of minor dermatological blemishes and marks or minor anatomical anomalies.

(12) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(13) Removal of tattoos.

(14) Hair transplants.

(15) Electrolysis.

(16) Any procedures related to transsexualism or such other conditions as gender dysphoria except as provided in subsection E.7. of this chapter.

(17) Penile implant procedure for psychological impotency, transsexualism or such other conditions as gender dysphoria.

(18) Insertion of prosthetic testicles for transsexualism or such other conditions as gender dysphoria.

9. Complications (unfortunate sequelae) resulting from noncovered initial surgery or treatment. Benefits are available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident of treatment (such as nonadjunctive dental care, transsexual surgery, and cosmetic surgery) but only if the later complication represents a separate medical condition such as a systemic infection, cardiac arrest, and acute drug reaction. Benefits may not be extended for any later care or procedures related to the complication that essentially is similar to the initial noncovered care. Examples of complications similar to the initial episode of care (and thus not covered) would be repair of facial scarring resulting from dermabrasion for acne or repair of a prolapsed vagina in a biological male who had undergone transsexual surgery.

10. Dental. CHAMPUS does not include a dental benefit. Under very limited circumstances, benefits are available for dental services and supplies when the dental services are adjunctive to otherwise covered medical treatment.

a. Adjunctive dental care, limited. Adjunctive dental care is limited to those services and supplies provided under the following conditions:

(1) Dental care which is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition and is essential to the control of the primary medical condition. The following is a list of conditions for which CHAMPUS benefits are payable under this provision:

- (a) Intraoral abscesses which extend beyond the dental alveolus.
- (b) Extraoral abscesses.
- (c) Cellulitis and osteitis which is clearly exacerbating and directly affecting a medical condition currently under treatment.
- (d) Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.
- (e) Myofacial Pain Dysfunction Syndrome.
- (f) Total or complete ankyloglossia.
- (g) Adjunctive dental and orthodontic support for cleft palate.
- (h) The prosthetic replacement of either the maxilla or the mandible due to the reduction of body tissues associated with traumatic injury (e.g., impact, gun shot wound), in addition to services related to treating neoplasms or iatrogenic dental trauma.

NOTE: The test of whether dental trauma is covered is whether the trauma is solely dental trauma. Dental trauma, in order to be covered, must be related to, and an integral part of medical trauma; or a result of medically necessary treatment of an injury or disease.

(2) Dental care required in preparation for medical treatment of a disease or disorder or required as the result of dental trauma caused by the medically necessary treatment of an injury or disease (iatrogenic).

(a) Necessary dental care including prophylaxis and extractions when performed in preparation for or as a result of in-line radiation therapy for oral or facial cancer.

(b) Treatment of gingival hyperplasia, with or without periodontal disease, as a direct result of prolonged therapy with Dilantin (diphenylhydantoin) or related compounds.

(c) Dental care is limited to the above and similar conditions specifically prescribed by the Director, OCHAMPUS, as meeting the requirements for coverage under the provisions of this section.

b. General exclusions.

(1) Dental care which is routine, preventative, restorative, prosthodontic, periodontic or emergency does not qualify as adjunctive dental care for the purposes of CHAMPUS except when performed in preparation for or as a result of dental trauma caused by medically necessary treatment of an injury or disease.

(2) The adding or modifying of bridgework and dentures.

(3) Orthodontia, except when directly related to and an integral part of the medical or surgical correction of a cleft palate or when required in preparation for, or as a result of, trauma to the teeth and supporting structures caused by medically necessary treatment of an injury or disease.

c. Preauthorization required. In order to be covered, adjunctive dental care requires preauthorization from the Director, OCHAMPUS, or a designee, in accordance with subsection A.11. of this chapter. When adjunctive dental care involves a medical (not dental) emergency (such as facial injuries resulting from an accident), the requirement for preauthorization is waived. Such waiver, however, is limited to the essential adjunctive dental care related to the medical condition requiring the immediate emergency treatment. A complete explanation, with supporting medical documentation, must be submitted with claims for emergency adjunctive dental care.

d. Covered oral surgery. Notwithstanding the above limitations on dental care, there are certain oral surgical procedures that are performed by both physicians and dentists, and that are essentially medical rather than dental care. For the purposes of CHAMPUS, the following procedures, whether performed by a physician or dentist, are considered to be in this category and benefits may be extended for otherwise covered services and supplies without preauthorization:

(1) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, and roof and floor of the mouth, when such conditions require a pathological (histological) examination.

(2) Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, and roof and floor of the mouth.

(3) Treatment of oral or facial cancer.

(4) Treatment of fractures of facial bones.

(5) External (extra-oral) incision and drainage of cellulitis.

(6) Surgery of accessory sinuses, salivary glands, or ducts.

(7) Reduction of dislocations and the excision of the temporomandibular joints, when surgery is a necessary part of the reduction.

(8) Any oral surgical procedure that falls within the cosmetic, reconstructive, or plastic surgery definition is subject to the limitations and requirements set forth in subsection E.8. of this chapter.

NOTE: Extraction of unerupted or partially erupted, malposed or impacted teeth, with or without the attached follicular or development tissues, is not a covered oral surgery procedure except when the care is indicated in preparation for medical treatment of a disease or disorder or required as a result of dental trauma caused by the necessary medical treatment of an injury or illness. Surgical preparation of the mouth for dentures is not covered by CHAMPUS.

e. Inpatient hospital stay in connection with nonadjunctive, noncovered dental care. Institutional benefits specified in section B. of this chapter may be extended for inpatient hospital stays related to noncovered, nonadjunctive dental care when such inpatient stay is medically necessary to safeguard the life of the patient from the effects of dentistry because of the existence of a specific and serious nondental organic impairment currently under active treatment. (Hemophilia is an example of a condition that could be considered a serious nondental impairment.) Preauthorization by the Director, OCHAMPUS, or a designee, is required for such inpatient stays to be covered in the same manner as required for adjunctive dental care described in paragraph E.10.c. of this chapter. Regardless of whether or not the preauthorization request for the hospital admission is approved and thus qualifies for institutional benefits, the professional service related to the nonadjunctive dental care is not covered.

11. Drug abuse. Under the Basic Program, benefits may be extended for medically necessary prescription drugs required in the treatment of an illness or injury or in connection with maternity care (refer to section D. of this chapter). However, CHAMPUS benefits cannot be authorized to support or maintain an existing or potential drug abuse situation, whether or not the drugs (under other circumstances) are eligible for benefit consideration and whether or not obtained by legal means.

a. Limitations on who can prescribe drugs. CHAMPUS benefits are not available for any drugs prescribed by a member of the beneficiary's family or by a nonfamily member residing in the same household with the beneficiary or sponsor.

b. Drug maintenance programs excluded. Drug maintenance programs when one addictive drug is substituted for another on a maintenance basis (such as methadone substituted for heroin) are not covered. This exclusion applies even in areas outside the United States where addictive drugs are dispensed legally by physicians on a maintenance dosage level.

c. Kinds of prescription drugs that are monitored carefully by CHAMPUS for possible abuse situations.

- (1) Narcotics. Examples are Morphine and Demerol.
- (2) Nonnarcotic analgesics. Examples are Talwin and Darvon.
- (3) Tranquilizers. Examples are Valium, Librium, and Meproamate.
- (4) Barbiturates. Examples are Seconal and Nembutal.
- (5) Nonbarbiturate hypnotics. Examples are Doriden and Chloral Hydrate.
- (6) Stimulants. Examples are amphetamines.

d. CHAMPUS fiscal intermediary responsibilities. CHAMPUS fiscal intermediaries are responsible for implementing utilization control and quality assurance procedures designed to identify possible drug abuse situations. The CHAMPUS fiscal intermediary is directed to screen all drug claims for potential overutilization and irrational prescribing of drugs, and to subject any such cases to extensive review to establish the necessity for the drugs and their appropriateness on the basis of diagnosis or definitive symptoms.

(1) When a possible drug abuse situation is identified, all claims for drugs for that specific beneficiary or provider will be suspended pending the results of a review.

(2) If the review determines that a drug abuse situation does in fact exist, all drug claims held in suspense will be denied.

(3) If the record indicates previously paid drug benefits, the prior claims for that beneficiary or provider will be reopened and the circumstances involved reviewed to determine whether or not drug abuse also existed at the time the earlier claims were adjudicated. If drug abuse is later ascertained, benefit payments made previously will be considered to have been extended in error and the amounts so paid recouped.

(4) Inpatient stays primarily for the purpose of obtaining drugs and any other services and supplies related to drug abuse also are excluded.

e. Unethical or illegal provider practices related to drugs. Any such investigation into a possible drug abuse that uncovers unethical or illegal drug dispensing practices on the part of an institution, a pharmacy, or physician will be referred to the professional or investigative agency having jurisdiction. CHAMPUS fiscal intermediaries are directed to withhold payment of all CHAMPUS claims for services and supplies rendered by a provider under active investigation for possible unethical or illegal drug dispensing activities.

f. Detoxification. The above monitoring and control of drug abuse situations shall in no way be construed to deny otherwise covered medical services and supplies related to drug detoxification (including newborn, addicted infants) when medical supervision is required.

12. Custodial care. The statute under which CHAMPUS operates specifically excludes custodial care. Many beneficiaries and sponsors misunderstand what is meant by custodial care, assuming that because custodial care is not covered, it implies the custodial care is not necessary. This is not the case; it only means the care being provided is not a type of care for which CHAMPUS benefits can be extended.

a. Kinds of conditions that can result in custodial care. There is no absolute rule that can be applied. With most conditions, there is a period of active treatment before custodial care, some much more prolonged than others. Examples of potential custodial care cases may be a spinal cord injury resulting in extensive paralysis, a severe cerebral vascular accident, multiple sclerosis in its latter stages, or presenile and senile dementia. These conditions do not result necessarily in custodial care but are indicative of the types of conditions that sometimes do. It is not the condition itself that is controlling, but whether the care being rendered falls within the definition of custodial care (refer to Chapter 2 of this Regulation for the definition of "custodial care").

b. Benefits available in connection with a custodial care case. CHAMPUS benefits are not available for services related to a custodial care case, with the following specific exceptions:

(1) Prescription drugs and medicines, medical supplies and durable medical equipment. Benefits are payable for otherwise covered prescription drugs and medicines, medical supplies and durable medical equipment.

(2) Nursing services, limited. Recognizing that even though the care being received is determined primarily to be custodial, an occasional specific skilled nursing service may be required. When it is determined such skilled nursing services are needed, benefits may be extended for 1 hour of nursing care per day.

(3) Physician services, limited. Recognizing that even though the care being received is determined primarily to be custodial, occasional physician monitoring may be required to maintain the patient's condition. When it is determined that a patient is receiving custodial care, benefits may be extended for up to twelve physician visits per calendar year for the custodial condition (not to exceed one per month).

NOTE: CHAMPUS benefits may be extended for additional physician visits related to the treatment of a condition other than the condition for which the patient is receiving custodial care (an example is a broken leg as a result of a fall).

(4) Payment for prescription drugs, medical supplies, durable medical equipment and limited skilled nursing and physician services does not affect custodial care determination. The fact that CHAMPUS extends benefits for prescription drugs, medical supplies, durable medical equipment, and limited skilled nursing and physician services in no way affects the custodial care determination if the case otherwise falls within the definition of custodial care.

c. Exception to custodial care exclusion, admission to a hospital. CHAMPUS benefits may be extended for otherwise covered services or supplies directly related to a medically necessary admission to an acute care general or special hospital (as defined in paragraph B.4.a., Chapter 6, of this Regulation), if the care is at the appropriate level and meets other requirements of this Regulation.

d. Reasonable care for which benefits were authorized or reimbursed before June 1, 1977. It is recognized that care for which benefits were authorized or reimbursed before the implementation date of the Regulation may be excluded under the custodial care limitations set forth in this Regulation. Therefore, an exception to the custodial care limitations set forth in this Regulation exists whereby reasonable care for which benefits authorized or reimbursed under the Basic Program before June 1, 1977, shall continue to be authorized even though the care would be excluded as a benefit under the custodial care limitations of the Regulation. Continuation of CHAMPUS benefits in such cases is limited as follows:

(1) Initial authorization or reimbursement before June 1, 1977. The initial CHAMPUS authorization or reimbursement for the care occurred before June 1, 1977; and,

(2) Continued care. The care has been continuous since the initial CHAMPUS authorization or reimbursement; and,

(3) Reasonable care. The care is reasonable. CHAMPUS benefits shall be continued for reasonable care up to the same level of benefits and for the same period of eligibility authorized or reimbursed before June 1, 1977. Care that is excessive or otherwise unreasonable will be reduced or eliminated from the continued care authorized under this exception.

13. Domiciliary care. The statute under which CHAMPUS operates also specifically excludes domiciliary care (refer to Chapter 2 of this Regulation for the definition of "Domiciliary Care").

a. Examples of domiciliary care situations. The following are examples of domiciliary care for which CHAMPUS benefits are not payable.

(1) Home care is not available. Institutionalization primarily because parents work, or extension of a hospital stay beyond what is medically necessary because the patient lives alone, are examples of domiciliary care provided because there is no other family member or other person available in the home.

(2) Home care is not suitable. Institutionalization of a child because a parent (or parents) is an alcoholic who is not responsible enough to care for the child, or because someone in the home has a contagious disease, are examples of domiciliary care being provided because the home setting is unsuitable.

(3) Family unwilling to care for a person in the home. A child who is difficult to manage may be placed in an institution, not because institutional care is medically necessary, but because the family does not want to handle him or her in the home. Such institutionalization would represent domiciliary care, that is, the family being unwilling to assume responsibility for the child.

b. Benefits available in connection with a domiciliary care case. Should the beneficiary receive otherwise covered medical services or supplies while also being in a domiciliary care situation, CHAMPUS benefits are payable for those medical services or supplies, or both, in the same manner as though the beneficiary resided in his or her own home. Such benefits would be cost-shared as though rendered to an outpatient.

c. General exclusion. Domiciliary care is institutionalization essentially to provide a substitute home--not because it is medically necessary for the beneficiary to be in the institution (although there may be conditions present that have contributed to the fact that domiciliary care is being rendered). CHAMPUS benefits are not payable for any costs or charges related to the provision of domiciliary care. While a substitute home or assistance may be necessary for the beneficiary, domiciliary care does not represent the kind of care for which CHAMPUS benefits can be provided.

14. CT scanning

a. Approved CT scan services. Benefits may be extended for medically necessary CT scans of the head or other anatomical regions of the body when all of the following conditions are met:

(1) The patient is referred for the diagnostic procedure by a physician.

(2) The CT scan procedure is consistent with the preliminary diagnosis or symptoms.

(3) Other noninvasive and less costly means of diagnosis have been attempted or are not appropriate.

(4) The CT scan equipment is licensed or registered by the appropriate state agency responsible for licensing or registering medical equipment that emits ionizing radiation.

(5) The CT scan equipment is operated under the general supervision and direction of a physician.

(6) The results of the CT scan diagnostic procedure are interpreted by a physician.

b. Review guidelines and criteria. The Director, OCHAMPUS, or a designee, will issue specific guidelines and criteria for CHAMPUS coverage of medically necessary head and body part CT scans.

15. Morbid obesity. The CHAMPUS morbid obesity benefit is limited to the gastric bypass, gastric stapling, or gastroplasty method.

a. Conditions for coverage. Payment may be extended for the gastric bypass, gastric stapling, or gastroplasty method only when one of the following conditions is met:

(1) The patient is 100 pounds over the ideal weight for height and bone structure and has an associated severe medical condition. These associated medical conditions are diabetes mellitus, hypertension, cholecystitis, narcolepsy, pickwickian syndrome (and other severe respiratory diseases), hypothalamic disorders, and severe arthritis of the weight-bearing joints.

(2) The patient is 200 percent or more of the ideal weight for height and bone structure. An associated medical condition is not required for this category.

(3) The patient has had an intestinal bypass or other surgery for obesity and, because of complications, requires a second surgery (a takedown). The surgeon in many cases, will do a gastric bypass, gastric stapling, or gastroplasty to help the patient avoid regaining the weight that was lost. In this situation, payment is authorized even though the patient's condition technically may not meet the definition of morbid obesity because of the weight that was already lost following the initial surgery.

b. Exclusions

(1) CHAMPUS payment may not be made for nonsurgical treatment of obesity or morbid obesity, for dietary control, or weight reduction.

(2) CHAMPUS payment may not be made for surgical procedures other than the gastric bypass, gastric stapling, or gastroplasty, even if morbid obesity is present.

16. Maternity care.

a. Benefit. The CHAMPUS Basic Program may share the cost of medically necessary services and supplies associated with maternity care which are not otherwise excluded by this Regulation. However, failure by a beneficiary to secure a required Nonavailability Statement (NAS) (DD Form 1251) as set forth in subsection A. 9. of this Chapter will waive that beneficiary's right to CHAMPUS cost-share of certain maternity care services and supplies.

b. Cost-share. Subject to applicable NAS requirements, maternity care cost-share shall be determined as follows:

(1) Inpatient cost-share formula applies to maternity care ending in childbirth in, or on the way to, a hospital inpatient childbirth unit, and for maternity care ending in a non-birth outcome not otherwise excluded by this Regulation.

(2) Ambulatory surgery cost-share formula applies to maternity care ending in childbirth in, or on the way to, a birthing center to which the beneficiary is admitted and from which the beneficiary has received prenatal care, or a hospital-based outpatient birthing room.

(3) Outpatient cost-share formula applies to maternity care which terminates in a planned childbirth at home.

(4) Otherwise covered medical services and supplies directly related to "Complications of Pregnancy," as defined in Chapter 2 will be cost-shared on the same basis as the related maternity care for a period not to exceed 42 days following termination of the pregnancy and thereafter cost-shared on the basis of the inpatient or outpatient status of the beneficiary when medically necessary services and supplies are received.

17. Biofeedback Therapy. Biofeedback therapy is a technique by which a person is taught to exercise control over a physiologic process occurring within the body. By using modern biomedical instruments the patient learns how a specific physiologic system within his body operates and how to modify the performance of this particular system.

a. Benefits provided. CHAMPUS benefits are payable for services and supplies in connection with electrothermal, electromyograph and electrodermal biofeedback therapy when there is documentation that the patient has undergone an appropriate medical evaluation, that their present condition is not responding to or no longer responds to other forms of conventional treatment, and only when provided as treatment for the following conditions:

(1) Adjunctive treatment for Raynaud's Syndrome.

(2) Adjunctive treatment for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, or incapacitating muscle spasm or weakness.

b. Limitations. Payable benefits include initial intake evaluation. Treatment following the initial intake evaluation is limited to a maximum of 20 inpatient and outpatient biofeedback treatments per calendar year.

c. Exclusions. Benefits are excluded for biofeedback therapy for the treatment of ordinary muscle tension states or for psychosomatic conditions. Benefits are also excluded for the rental or purchase of biofeedback equipment.

d. Provider requirements. A provider of biofeedback therapy must be a CHAMPUS-authorized provider. (Refer to CHAPTER 6, "Authorized Providers.") If biofeedback treatment is provided by other than a physician, the patient must be referred by a physician.

e. Implementation Guidelines. The Director, OCHAMPUS, shall issue guidelines as are necessary to implement the provisions of this paragraph.

18. Cardiac Rehabilitation. Cardiac rehabilitation is the process by which individuals are restored to their optimal physical, medical and psychological status, after a cardiac event. Cardiac rehabilitation is often divided into three phases. Phase I begins during inpatient hospitalization and is managed by the patient's personal physician. Phase II is a medically supervised outpatient program which begins following discharge. Phase III is a lifetime maintenance program emphasizing continuation of physical fitness with periodic followup. Each phase includes an exercise component, patient education, and risk factor modification. There may be considerable variation in program components, intensity and duration.

a. Benefits Provided. CHAMPUS benefits are available on an inpatient or outpatient basis for services and supplies provided in connection with a cardiac rehabilitation program when ordered by a physician and provided as treatment for patients who have experienced the following cardiac events within the preceding twelve (12) months:

- (1) Myocardial Infarction.
- (2) Coronary Artery Bypass Graft.
- (3) Coronary Angioplasty.
- (4) Percutaneous Transluminal Coronary Angioplasty.
- (5) Chronic Stable Angina (see limitations below).

b. Limitations. Payable benefits include separate allowance for the initial evaluation and testing. Outpatient treatment following the initial intake evaluation and testing is limited to a maximum of thirty-six (36) sessions per cardiac event, usually provided 3 sessions per week for twelve weeks. Patient's diagnosed with chronic stable angina are limited to one treatment episode (36 sessions) in a calendar year.

c. Exclusions. Phase III cardiac rehabilitation lifetime maintenance programs performed at home or in medically unsupervised settings are not covered.

d. Providers. A provider of cardiac rehabilitation services must be a CHAMPUS authorized hospital. (Refer to Chapter 6, "Authorized Providers.") All cardiac rehabilitation services must be ordered by a physician.

e. Payment. Payment for outpatient treatment will be based on an all inclusive allowable charge per session. Inpatient treatment will be paid based upon the reimbursement system in place for the hospital where the services are rendered.

f. Implementation Guidelines: The Director of OCHAMPUS shall issue guidelines as are necessary to implement the provisions of this paragraph.

19. Hospice care. Hospice care is a program which provides an integrated set of services and supplies designed to care for the terminally ill. This type of care emphasizes palliative care and supportive services, such as pain control and home care, rather than cure-oriented services provided in institutions that are otherwise the primary focus under CHAMPUS. The benefit provides coverage for a humane and sensible approach to care during the last days of life for some terminally ill patients.

a. Benefit coverage. CHAMPUS beneficiaries who are terminally ill (that is, a life expectancy of six months or less if the disease runs its normal course) will be eligible for the following services and supplies in lieu of most other CHAMPUS benefits:

(1) Physician services.

(2) Nursing care provided by or under the supervision of a registered professional nurse.

(3) Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician. Medical social services include, but are not limited to the following:

(a) Assessment of social and emotional factors related to the beneficiary's illness, need for care, response to treatment, and adjustment to care.

(b) Assessment of the relationship of the beneficiary's medical and nursing requirements to the individual's home situation, financial resources, and availability of community resources.

(c) Appropriate action to obtain available community resources to assist in resolving the beneficiary's problem.

(d) Counseling services that are required by the beneficiary.

(4) Counseling services provided to the terminally ill individual and the family member or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care-giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. Bereavement counseling, which consists of counseling services provided to the individual's family after the individual's death, is a required hospice service but it is not reimbursable.

(5) Home health aide services furnished by qualified aides and homemaker services. Home health aides may provide personal care services. Aides also may perform household services to maintain a safe and sanitary environment in areas of the home used by the patient. Examples of such services are changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the individual to carry out the plan of care. Qualifications for home health aides can be found in 42 C.F.R. section 484.36.

(6) Medical appliances and supplies, including drugs and biologicals. Only drugs that are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment, as well as other self-help and personal comfort items related to the palliation or management of the patient's condition while he or she is under hospice care. Equipment is provided by the hospice for use in the beneficiary's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care. Medical appliances and supplies are included within the hospice all-inclusive rates.

(7) Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

(8) Short-term inpatient care provided in a Medicare participating hospice inpatient unit, or a Medicare participating hospital, skilled nursing facility (SNF) or, in the case of respite care, a Medicaid-certified nursing facility that additionally meets the special hospice standards regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. Inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home. Respite care is the only type of inpatient care that may be provided in a Medicaid-certified nursing facility. The limitations on custodial care and personal comfort items applicable to other CHAMPUS services are not applicable to hospice care.

b. Core services. The hospice must ensure that substantially all core services are routinely provided directly by hospice employees; i.e., physician services, nursing care, medical social services, and counseling for individuals and care givers. Refer to paragraphs E.19.a.(1), E.19.a.(2), E.19.a.(3), and E.19.a.(4) of this chapter.

c. Non-core services. While non-core services (i.e., home health aide services, medical appliances and supplies, drugs and biologicals, physical therapy, occupational therapy, speech-language pathology and short-term inpatient care) may be provided under arrangements with other agencies or organizations, the hospice must maintain professional management of the patient at all times and in all settings. Refer to paragraphs E.19.a.(5), E.19.a.(6), E.19.a.(7), and E.19.a.(8) of this chapter.

d. Availability of services. The hospice must make nursing services, physician services, and drugs and biologicals routinely available on a 24-hour basis. All other covered services must be made available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of the terminal illness and related condition. These services must be provided in a manner consistent with accepted standards of practice.

e. Periods of care. Hospice care is divided into distinct periods/episodes of care. The terminally ill beneficiary may elect to receive hospice benefits for an initial period of 90 days, a subsequent period of 90 days, a second subsequent period of 30 days, and a final period of unlimited duration.

f. Conditions for coverage. The CHAMPUS beneficiary must meet the following conditions/criteria in order to be eligible for the hospice benefits and services referenced in paragraph E.19.a. of this chapter.

(1) There must be written certification in the medical record that the CHAMPUS beneficiary is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

(a) Timing of certification. The hospice must obtain written certification of terminal illness for each of the election periods described in paragraph E.19.f.(2) of this chapter, even if a single election continues in effect for two, three or four periods.

1 Basic requirement. Except as provided in paragraph E.19.f.(1)(a)2 of this chapter, the hospice must obtain the written certification no later than two calendar days after the period begins.

2 Exception. For the initial 90-day period, if the hospice cannot obtain the written certifications within two calendar days, it must obtain oral certifications within two calendar days, and written certifications no later than eight calendar days after the period begins.

(b) Sources of certification. Physician certification is required for both initial and subsequent election periods.

1 For the initial 90-day period, the hospice must obtain written certification statements (and oral certification statements if required under paragraph E.19.f.(1)(a)2 of this chapter) from:

a The individual's attending physician if the individual has an attending physician; and

b The medical director of the hospice or the physician member of the hospice interdisciplinary group.

2 For subsequent periods, the only requirement is certification by one of the physicians listed in paragraph E.19.f.(1)(b)1 b of this section.

(2) The terminally ill beneficiary must elect to receive hospice care for each specified period of time; i.e., the two 90-day periods, a subsequent 30-day period, and a final period of unlimited duration. If the individual is found to be mentally incompetent, his or her representative may file the election statement. Representative means an individual who has been authorized under State law to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is found to be mentally incompetent.

(a) The episodes of care must be used consecutively; i.e., the two 90-day periods first, then the 30-day period, followed by the final period. The periods of care may be elected separately at different times.

(b) The initial election will continue through subsequent election periods without a break in care as long as the individual remains in the care of the hospice and does not revoke the election.

(c) The effective date of the election may begin on the first day of hospice care or any subsequent day of care, but the effective date cannot be made prior to the date that the election was made.

(d) The beneficiary or representative may revoke a hospice election at any time, but in doing so, the remaining days of that particular election period are forfeited and standard CHAMPUS coverage resumes. To revoke the hospice benefit, the beneficiary or representative must file a signed statement of revocation with the hospice. The statement must provide the date that the revocation is to be effective. An individual or representative may not designate an effective date earlier than the date that the revocation is made.

(e) If an election of hospice benefits has been revoked, the individual, or his or her representative may at any time file a hospice election for any period of time still available to the individual, in accordance with Chapter 4.E.19.f.(2).

(f) A CHAMPUS beneficiary may change, once in each election period, the designation of the particular hospice from which he or she elects to receive hospice care. To change the designation of hospice programs the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following information:

1 The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care.

2 The date the change is to be effective.

(g) Each hospice will design and print its own election statement to include the following information:

1 Identification of the particular hospice that will provide care to the individual.

2 The individual's or representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness.

3 The individual's or representative's acknowledgment that he or she understands that certain other CHAMPUS services are waived by the election.

4 The effective date of the election.

5 The signature of the individual or representative, and the date signed.

(h) The hospice must notify the CHAMPUS contractor of the initiation, change or revocation of any election.

(3) The beneficiary must waive all rights to other CHAMPUS payments for the duration of the election period for:

(a) Care provided by any hospice program other than the elected hospice unless provided under arrangements made by the elected hospice; and

(b) Other CHAMPUS basic program services/benefits related to the treatment of the terminal illness for which hospice care was elected, or to a related condition, or that are equivalent to hospice care, except for services provided by:

1 the designated hospice;

2 another hospice under arrangements made by the designated hospice; or

3 an attending physician who is not employed by or under contract with the hospice program.

(c) Basic CHAMPUS coverage will be reinstated upon revocation of the hospice election.

(4) A written plan of care must be established by a member of the basic interdisciplinary group assessing the patient's needs. This group must have at least one physician, one registered professional nurse, one social worker, and one pastoral or other counselor.

(a) In establishing the initial plan of care the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member before writing the initial plan of care.

(b) At least one of the persons involved in developing the initial plan must be a nurse or physician.

(c) The plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care.

(d) The other two members of the basic interdisciplinary group -- the attending physician and the medical director or physician designee -- must review the initial plan of care and provide their input to the process of establishing the plan of care within two calendar days following the day of assessment. A meeting of group members is not required within this 2-day period. Input may be provided by telephone.

(e) Hospice services must be consistent with the plan of care for coverage to be extended.

(f) The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, medical director or physician designee and interdisciplinary group. These reviews must be documented in the medical records.

(g) The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

(h) The plan must include an assessment of the individual's needs and identification of the services, including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

(5) Complete medical records and all supporting documentation must be submitted to the CHAMPUS contractor within 30 days of the date of its request. If records are not received within the designated time frame, authorization of the hospice benefit will be denied and any prior payments made will be recouped. A denial issued for this reason is not an initial determination under Chapter 10, and is not appealable.

g. Appeal rights under hospice benefit. A beneficiary or provider is entitled to appeal rights for cases involving a denial of benefits in accordance with the provisions of this Chapter and Chapter 10.

F. BENEFICIARY OR SPONSOR LIABILITY

1. General. As stated in the introductory paragraph to this chapter, the Basic Program is essentially a supplemental program to the Uniformed Services direct medical care system. To encourage use of the Uniformed Services direct medical care system wherever its facilities are available and appropriate, the Basic Program benefits are designed so that it is to the financial advantage of a CHAMPUS beneficiary or sponsor to use the direct medical care system. When medical care is received from civilian sources, a CHAMPUS beneficiary is responsible for payment of certain deductible and cost-sharing amounts in connection with otherwise covered services and supplies. By statute, this joint financial responsibility between the beneficiary or sponsor and CHAMPUS is more favorable for dependents of active duty members than for other classes of beneficiaries.

2. Dependents of active duty members of the Uniformed Services. CHAMPUS beneficiary or sponsor liability set forth for dependents of active duty members is as follows:

a. Annual fiscal year deductible for outpatient services and supplies.

(1) For care rendered all eligible beneficiaries prior to April 1, 1991, or when the active duty sponsor's pay grade is E-4 or below, regardless of the date of care:

(a) **Individual Deductible:** Each beneficiary is liable for the first fifty dollars (\$50.00) of the CHAMPUS-determined allowable amount on claims for care provided in the same fiscal year.

(b) **Family Deductible:** The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed one hundred dollars (\$100.00).

(2) For care rendered on or after April 1, 1991, for all CHAMPUS beneficiaries except dependents of active duty sponsors of pay grades E-4 or below:

(a) **Individual Deductible:** Each beneficiary is liable for the first one hundred and fifty dollars (\$150.00) of the CHAMPUS-determined allowable amount on claims for care provided in the same fiscal year.

(b) **Family Deductible:** The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed three hundred dollars (\$300.00).

(3) CHAMPUS-Approved Ambulatory Surgical Centers or Birthing Centers. No deductible shall be applied to allowable amounts for services or items rendered to active duty or authorized NATO dependents.

(4) Allowable Amount does not exceed Deductible Amount. If fiscal year allowable amounts for two or more beneficiary members of a family total less than \$100.00 (\$300.00 if 2.a.(2)(b) above applies), but none of the beneficiary members submit a claim for over \$50.00 (\$150.00 if 2.a.(2)(a) above applies), neither the family nor the individual deductible will have been met and no CHAMPUS benefits are payable.

(5) For any family the outpatient deductible amounts will be applied sequentially as the CHAMPUS claims are processed.

(6) If the fiscal year outpatient deductible under either F.2.a.(1) or F.2.a.(2) above has been met by a beneficiary or a family through the submission of a claim or claims to a CHAMPUS fiscal intermediary in another geographic location from the location where a current claim is being submitted, the beneficiary or sponsor must obtain a deductible certificate from the CHAMPUS fiscal intermediary where the applicable beneficiary or family fiscal year deductible was met. Such deductible certificate must be attached to the current claim being submitted for benefits. Failure to obtain a deductible certificate under such circumstances will result in a second beneficiary or family fiscal year deductible being applied. However, this second deductible may be reimbursed once appropriate documentation, as described in this subparagraph F.2.a.(6), is supplied to the CHAMPUS fiscal intermediary applying the second deductible (refer to section A. of Chapter 7 of this Regulation).

(7) Notwithstanding the dates specified in paragraphs F.2.a.(1) and (2), in the case of the dependents of active duty members of rank E-5 or above with Persian Gulf conflict service, the deductible shall be the amount specified in paragraph (1) for care rendered prior to October 1, 1991, and the amount specific in

paragraph (2) for care rendered after October 1, 1991. For purposes of the preceding sentence, a member with Persian Gulf conflict service is a member who is, or was entitled to special pay for hostile fire/imminent danger authorized by 37 U.S.C. 310, for services in the Persian Gulf area in connection with Operation Desert Shield or Operation Desert Storm.

b. Inpatient cost-sharing. Except in the case of mental health services (see paragraph F.2.b.(4) of this chapter), dependents of active duty members of the Uniformed Services or their sponsors are responsible for the payment of the first \$25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider (refer to chapter 6), or the amount the beneficiary or sponsor would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater.

NOTE: The Secretary of Defense (after consulting with the Secretary of Health and Human Services and the Secretary of Transportation) prescribes the fair charges for inpatient hospital care provided through Uniformed Services medical facilities. This determination is made each fiscal year.

(1) Inpatient cost-sharing payable with each separate inpatient admission. A separate cost-sharing amount (as described in this subsection F.2.) is payable for each inpatient admission to a hospital or other authorized institution, regardless of the purpose of the admission (such as medical or surgical), regardless of the number of times the beneficiary is admitted, and regardless of whether or not the inpatient admissions are for the same or related conditions; except that successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the inpatient cost-share payable, provided not more than 60 days have elapsed between the successive admissions. However, notwithstanding this provision, all admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions (refer to section B. of this chapter).

(2) Multiple family inpatient admissions. A separate cost-sharing amount is payable for each inpatient admission, regardless of whether or not two or more beneficiary members of a family are admitted at the same time or from the same cause (such as an accident). A separate beneficiary inpatient cost-sharing amount must be applied for each separate admission on each beneficiary member of the family.

(3) Newborn patient in his or her own right. When a newborn infant remains as an inpatient in his or her own right (usually after the mother is discharged), the newborn child becomes the beneficiary and patient and the extended inpatient stay becomes a separate inpatient admission. In such a situation, a new, separate inpatient cost-sharing amount is applied. If a multiple birth is involved (such as twins or triplets) and two or more newborn infants become patients in their own right, a separate inpatient cost-sharing amount must be applied to the inpatient stay for each newborn child who has remained as an inpatient in his or her own right.

(4) Inpatient cost-sharing for mental health services. For care provided on or after October 1, 1995, the inpatient cost-sharing for mental health services is \$20 per day for each day of the inpatient admission. This \$20 per day cost sharing amount applies to admissions to any hospital for mental health services, any residential treatment facility, any substance abuse rehabilitation facility, and any partial hospitalization program providing mental health or substance use disorder rehabilitation services.

c. Outpatient cost-sharing. Dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of 20 percent of the CHAMPUS-determined allowable cost or charge beyond the annual fiscal year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

d. Ambulatory surgery. Notwithstanding the above provisions pertaining to outpatient cost-sharing, dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of \$25 for surgical care that is authorized and received while in an outpatient status and that has been designated in guidelines issued by the Director, OCHAMPUS, or a designee.

e. Psychiatric partial hospitalization services. Institutional and professional services provided under the psychiatric partial hospitalization program authorized by paragraph B.10. of this chapter shall be cost-shared as inpatient services.

3. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees. CHAMPUS beneficiary liability set forth for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. The annual fiscal year deductible for otherwise covered outpatient services or supplies provided retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees, is the same as the annual fiscal year outpatient deductible applicable to dependents of active duty members of rank E-5 or above (refer to paragraph F.2.a.(1) or (2) of this chapter).

b. Inpatient cost-sharing. Cost-sharing amounts for inpatient services shall be as follows:

(1) Services subject to the CHAMPUS DRG-based payment system. The cost-share shall be the lesser of an amount calculated by multiplying a per diem amount for each day of the hospital stay except the day of discharge or 25 percent of the hospital's billed charges. The per diem amount shall be calculated so that total cost-sharing amounts for these beneficiaries is equivalent to 25 percent of the CHAMPUS-determined allowable costs for covered services or supplies provided on an inpatient basis by authorized providers. The per diem amount shall be published annually by CHAMPUS.

(2) Services subject to the mental health per diem payment system. The cost-share is dependent upon whether the hospital is paid a hospital-specific per diem or a regional per diem under the provisions of subsection A.2. of Chapter 14. With respect to care paid for on the basis of a hospital-specific per diem, the cost-share shall be 25% of the hospital-specific per diem amount. For care paid for on the basis of a regional per diem, the cost share shall be the lower of a fixed daily amount or 25% of the hospital's billed charges. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25% of total payments under the mental health per diem payment system. This fixed daily amount shall be updated annually and published in the Federal Register along with the per diems published pursuant to subparagraph A.2.d.(2) of Chapter 14.

(3) Other services. For services exempt from the CHAMPUS DRG-based payment system and the CHAMPUS mental health per diem payment system and services provided by institutions other than hospitals, the cost-share shall be 25% of the CHAMPUS-determined allowable charges.

c. Outpatient cost-sharing.

(1) For services other than ambulatory surgery services. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees are responsible for payment of 25 percent of the CHAMPUS-determined allowable costs or charges beyond the annual fiscal year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

(2) For services subject to the ambulatory surgery payment method. For services subject to the ambulatory surgery payment method set forth in Chapter 14 D., of this regulation, the cost share shall be the lesser of: 25 percent of the payment amount provided pursuant to Chapter 14.D.; or 25 percent of the center's billed charges.

d. Psychiatric partial hospitalization services. Institutional and professional services provided under the psychiatric partial hospitalization program authorized by paragraph B.10. of this chapter shall be cost-shared as inpatient services.

4. Former spouses. CHAMPUS beneficiary liability set forth for former spouses eligible under the provisions of paragraph B.2.b. of Chapter 3 is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. An eligible former spouse is responsible for the payment of the first \$150 of the CHAMPUS-determined reasonable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year. (Except for services received prior to April 1, 1991, the deductible amount is \$50.00). The former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of any CHAMPUS-eligible children.

b. Inpatient cost-sharing. Eligible former spouses are responsible for the payment of cost-sharing amounts the same as those required for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.

c. Outpatient cost-sharing. Eligible former spouses are responsible for payment of 25 percent of the CHAMPUS-determined reasonable costs or charges beyond the annual fiscal year deductible amount for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

5. Cost-Sharing under the Military-Civilian Health Services Partnership Program. Cost-sharing is dependent upon the type of partnership program entered into, whether external or internal. (See section P. of Chapter 1, for general requirements of the Military-Civilian Health Services Partnership Program.)

a. External Partnership Agreement. Authorized costs associated with the use of the civilian facility will be financed through CHAMPUS under the normal cost-sharing and reimbursement procedures applicable under CHAMPUS.

b. Internal Partnership Agreement. Beneficiary cost-share under internal agreements will be the same as charges prescribed for care in military treatment facilities.

6. Amounts over CHAMPUS-determined allowable costs or charges. It is the responsibility of the CHAMPUS fiscal intermediary to determine allowable costs for services and supplies provided by hospitals and other institutions and allowable charges for services and supplies provided by physicians, other individual professional providers, and other providers. Such CHAMPUS-determined allowable costs or charges are made in accordance with the provisions of Chapter 14. All CHAMPUS benefits, including calculation of the CHAMPUS or beneficiary cost-sharing amounts, are based on such CHAMPUS-determined allowable costs or charges. The effect on the beneficiary when the billed cost or charge is over the CHAMPUS-determined allowable amount is dependent upon whether or not the applicable claim was submitted on a participating basis on behalf of the beneficiary or submitted directly by the beneficiary on a nonparticipating basis and on whether the claim is for inpatient hospital services subject to the CHAMPUS DRG-based payment system. This provision applies to all classes of CHAMPUS beneficiaries.

NOTE: When the provider "forgives" or "waives" any beneficiary liability, such as amounts applicable to the annual fiscal year deductible for outpatient services or supplies, or the inpatient or outpatient cost-sharing as previously set forth in this section, the CHAMPUS-determined allowable charge or cost allowance (whether payable to the CHAMPUS beneficiary or sponsor, or to a participating provider) shall be reduced by the same amount.

a. Participating providers. There are several circumstances under which institutional and individual providers may be Participating Providers, either on a mandatory basis or a voluntary basis. See Chapter 6, A.8. A Participating Provider, whether participating for all claims or on a claim-by-claim basis, must accept the CHAMPUS-determined allowable amount as payment in full for the medical

services or supplies provided, and must accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing and deductible amounts paid by or on behalf of the beneficiary as payment in full for the covered medical services or supplies. Therefore, when costs or charges are submitted on a participating basis, the patient is not obligated to pay any amounts disallowed as being over the CHAMPUS-determined allowable cost or charge for authorized services or supplies.

b. Nonparticipating providers. Nonparticipating providers are those providers who do not agree on the CHAMPUS claim form to participate and thereby do not agree to accept the CHAMPUS-determined allowable costs or charges as the full charge. For otherwise covered services and supplies provided by such nonparticipating CHAMPUS providers, payment is made directly to the beneficiary or sponsor and the beneficiary is liable under applicable law for any amounts over the CHAMPUS-determined allowable costs or charges. CHAMPUS shall have no responsibility for any amounts over allowable costs or charges as determined by CHAMPUS.

7. [Reserved]

8. Cost-sharing for services provided under special discount arrangements.

a. General rule. With respect to services determined by the Director, OCHAMPUS (or designee) to be covered by Chapter 14, section I., the Director, OCHAMPUS (or designee) has authority to establish, as an exception to the cost-sharing amount normally required pursuant to this chapter, a different cost-share amount that appropriately reflects the application of the statutory cost-share to the discount arrangement.

b. Specific applications. The following are examples of applications of the general rule; they are not all inclusive.

(1) In the case of services provided by individual health care professionals and other noninstitutional providers, the cost-share shall be the usual percentage of the CHAMPUS allowable charge determined under Chapter 14, section I.

(2) In the case of services provided by institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under Chapter 14, section A.1. or per-diem amount under Chapter 14, section A.2.), if the discount rate is lower than the pre-set rate, the cost-share amount that would apply for a beneficiary other than an active duty dependent pursuant to the normal pre-set rate would be reduced by the same percentage by which the pre-set rate was reduced in setting the discount rate.

9. Waiver of deductible amounts or cost-sharing not allowed.

a. General rule. Because deductible amounts and cost sharing are statutorily mandated, except when specifically authorized by law (as determined by the Director, OCHAMPUS), a provider may not waive or forgive beneficiary liability for annual deductible amounts or inpatient or outpatient cost-sharing, as set forth in this chapter.

b. Exception for bad debts. This general rule is not violated in cases in which a provider has made all reasonable attempts to effect collection, without success, and determines in accordance with generally accepted fiscal management standards that the beneficiary liability in a particular case is an uncollectible bad debt.

c. Remedies for noncompliance. Potential remedies for noncompliance with this requirement include:

(1) A claim for services regarding which the provider has waived the beneficiary's liability may be disallowed in full, or, alternatively, the amount payable for such a claim may be reduced by the amount of the beneficiary liability waived.

(2) Repeated noncompliance with this requirement is a basis for exclusion of a provider.

G. EXCLUSIONS AND LIMITATIONS

In addition to any definitions, requirements, conditions, or limitations enumerated and described in other chapters of this Regulation, the following specifically are excluded from the Basic Program:

1. Not medically or psychologically necessary. Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or injury, for the diagnosis and treatment of pregnancy, or for well-baby care except as provided in the following paragraph.

2. Unnecessary diagnostic tests. X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms except for cancer screening mammography and cancer screening papanicolaou (PAP) smears provided under the terms and conditions contained in the guidelines adopted by the Director, OCHAMPUS.

3. Institutional level of care. Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.

4. Diagnostic admission. Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.

NOTE: If it is determined that the diagnostic x-ray, laboratory, and pathological services and machine tests performed during such admission were medically necessary and would have been covered if performed on an outpatient basis, CHAMPUS benefits may be extended for such diagnostic procedures only, but cost-sharing will be computed as if performed on an outpatient basis.

5. Unnecessary postpartum inpatient stay, mother or newborn. Postpartum inpatient stay of a mother for purposes of staying with the newborn infant (usually primarily for the purpose of breast feeding the infant) when the infant (but not the mother) requires the extended stay; or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.

6. Therapeutic absences. Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by the Director, OCHAMPUS, or a designee. For cost-sharing provisions refer to Chapter 14, paragraph F.3.

7. Custodial care. Custodial care regardless of where rendered, except as otherwise specifically provided in paragraphs E.12.b., E.12.c. and E.12.d. of this chapter.

8. Domiciliary care. Inpatient stays primarily for domiciliary care purposes.

9. Rest or rest cures. Inpatient stays primarily for rest or rest cures.

10. Amounts above allowable costs or charges. Costs of services and supplies to the extent amounts billed are over the CHAMPUS determined allowable cost or charge, as provided for in Chapter 14.

11. No legal obligation to pay, no charge would be made. Services or supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary or sponsor was not eligible under CHAMPUS; or whenever CHAMPUS is a secondary payer for claims subject to the CHAMPUS DRG-based payment system, amounts, when combined with the primary payment, which would be in excess of charges (or the amount the provider is obligated to accept as payment in full, if it is less than the charges).

12. Furnished without charge. Services or supplies furnished without charge.

13. Furnished by local, state, or Federal Government. Services and supplies paid for, or eligible for payment, directly or indirectly by a local, state, or Federal Government, except as provided under CHAMPUS, or by government hospitals serving the general public, or medical care provided by a Uniformed Service medical care facility, or benefits provided under title XIX of the Social Security Act (Medicaid) (reference (h)) (refer to Chapter 8 of this Regulation).

14. Study, grant, or research programs. Services and supplies provided as a part of or under a scientific or medical study, grant, or research program.

15. Not in accordance with accepted standards, experimental or investigational. Services and supplies not provided in accordance with accepted professional medical standards; or related to essentially experimental or investigational procedures or treatment regimens.

16. Immediate family, household. Services or supplies provided or prescribed by a member of the beneficiary's immediate family, or a person living in the beneficiary's or sponsor's household.

17. Double coverage. Services and supplies that are (or are eligible to be) payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare (refer to Chapter 8 of this Regulation).

18. Nonavailability Statement required. Services and supplies provided under circumstances or in geographic locations requiring a Nonavailability Statement (DD Form 1251), when such a statement was not obtained.

19. Preauthorization required. Services or supplies which require preauthorization if preauthorization was not obtained. Services and supplies which were not provided according to the terms of the preauthorization. The Director, OCHAMPUS, or a designee, may grant an exception to the requirement for preauthorization if the services otherwise would be payable except for the failure to obtain preauthorization.

20. Psychoanalysis or psychotherapy, part of education. Psychoanalysis or psychotherapy provided to a beneficiary or any member of the immediate family that is credited towards earning a degree or furtherance of the education or training of a beneficiary or sponsor, regardless of diagnosis or symptoms that may be present.

21. Runaways. Inpatient stays primarily to control or detain a runaway child, whether or not admission is to an authorized institution.

22. Services or supplies ordered by a court or other government agency. Services or supplies, including inpatient stays, directed or agreed to by a court or other governmental agency. However, those services and supplies (including inpatient stays) that otherwise are medically or psychologically necessary for the diagnosis or treatment of a covered condition and that otherwise meet all CHAMPUS requirements for coverage are not excluded.

23. Work-related (occupational) disease or injury. Services and supplies required as a result of occupational disease or injury for which any benefits are payable under a worker's compensation or similar law, whether or not such benefits have been applied for or paid; except if benefits provided under such laws are exhausted.

24. Cosmetic, reconstructive, or plastic surgery. Services and supplies in connection with cosmetic, reconstructive, or plastic surgery except as specifically provided in subsection E.8. of this chapter.

25. Surgery, psychological reasons. Surgery performed primarily for psychological reasons (such as psychogenic).

26. Electrolysis.

27. Dental care. Dental care or oral surgery, except as specifically provided in subsection E.10. of this chapter.

28. Obesity, weight reduction. Services and supplies related to obesity or weight reduction whether surgical or nonsurgical; wiring of the jaw or any procedure of similar purpose, regardless of the circumstances under which performed; except that benefits may be provided for the gastric bypass, gastric stapling, or gastroplasty procedures in connection with morbid obesity as provided in subsection E.15. of this chapter.

29. Transsexualism or such other conditions as gender dysphoria. Services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in subsection E.7. of this chapter.

30. Therapy or counseling for sexual dysfunctions or sexual inadequacies. Sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy for mental disorders involving sex deviations (e.g., transvestic fetishism), or other similar services, and any supplies provided in connection with therapy for sexual dysfunctions or inadequacies.

31. Corns, calluses, and toenails. Removal of corns or calluses or trimming of toenails and other routine podiatry services, except those required as a result of a diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

32. Dyslexia.

33. Surgical sterilization, reversal. Surgery to reverse surgical sterilization procedures.

34. Noncoital reproductive procedures including artificial insemination, in-vitro fertilization, gamete intrafallopian transfer and all other such reproductive technologies. Services and supplies related to artificial insemination (including semen donors and semen banks), in-vitro fertilization, gamete intrafallopian transfer and all other noncoital reproductive technologies.

35. Nonprescription contraceptives.

36. Tests to determine paternity or sex of a child. Diagnostic tests to establish paternity of a child; or tests to determine sex of an unborn child.

37. Preventive care. Preventive care, such as routine, annual, or employment requested physical examinations; routine screening procedures; immunizations; except that the following are not excluded:

a. Well-baby care, including newborn examination, Phenylketonuria (PKU) testing and newborn circumcision.

b. Rabies shots.

c. Tetanus shot following an accidental injury.

d. Rh immune globulin.

e. Genetic tests as specified in paragraph E.3.b. of this chapter.

f. Immunizations and physical examinations provided when required in the case of dependents of active duty military personnel who are traveling outside the United States as a result of an active member's duty assignment and such travel is being performed under orders issued by a Uniformed Service.

g. Screening mammography for asymptomatic women 35 years of age and older when provided under the terms and conditions contained in the guidelines adopted by the Director OCHAMPUS.

h. Cancer screening papanicolaou (PAP) smear for women who are or have been sexually active, and women 18 years of age and older under the terms and conditions contained in the guidelines adopted by the Director, OCHAMPUS.

38. Chiropractors and naturopaths. Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider.

39. Counseling. Counseling services that are not medically necessary in the treatment of a diagnosed medical condition; for example, educational counseling, vocational counseling, nutritional counseling, counseling for socioeconomic purposes, diabetic self-education programs, stress management, life style modification, etc. Services provided by a certified marriage and family therapist, pastoral or mental health counselor in the treatment of a mental disorder are covered only as specifically provided in Chapter 6. Services provided by alcoholism rehabilitation counselors and certified addiction counselors are covered only when rendered in a CHAMPUS-authorized treatment setting and only when the cost of those services is included in the facility's CHAMPUS-determined allowable cost-rate.

40. Acupuncture. Acupuncture, whether used as a therapeutic agent or as an anesthetic.

41. Hair transplants, wigs, or hairpieces

NOTE: In accordance with Section 744 of the DoD Appropriation Act for 1981 (reference (c)), CHAMPUS coverage for wigs or hairpieces is permitted effective December 15, 1980, under the conditions listed below. Continued availability of benefits will depend on the language of the annual DoD Appropriation Acts.

a. Benefits provided. Benefits may be extended, in accordance with the CHAMPUS-determined allowable charge, for one wig or hairpiece per beneficiary (lifetime maximum) when the attending physician certifies that alopecia has resulted from treatment of a malignant disease and the beneficiary certifies that a wig or hairpiece has not been obtained previously through the U.S. Government (including the Veterans Administration).

b. Exclusions. The wig or hairpiece benefit does not include coverage for the following:

(1) Alopecia resulting from conditions other than treatment of malignant disease.

(2) Maintenance, wig or hairpiece supplies, or replacement of the wig or hairpiece.

(3) Hair transplants or any other surgical procedure involving the attachment of hair or a wig or hairpiece to the scalp.

(4) Any diagnostic or therapeutic method or supply intended to encourage hair regrowth.

42. Education or training. Self-help, academic education or vocational training services and supplies, unless the provisions of Chapter 4, paragraph B.1.e., relating to general or special education, apply.

43. Exercise/Relaxation/Comfort Devices. Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

44. Exercise. General exercise programs, even if recommended by a physician and regardless of whether or not rendered by an authorized provider. In addition, passive exercises and range of motion exercises also are excluded, except when prescribed by a physician and rendered by a physical therapist concurrent to, and as an integral part of, a comprehensive program of physical therapy.

45. Audiologist, speech therapist. Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of treatment addressed to the physical defect itself and not to any educational or occupational deficit.

46. Vision care. Eye exercises or visual training (orthoptics).

47. Eye and hearing examinations. Eye and hearing examinations except as specifically provided in paragraph C.2.p. of this chapter or except when rendered in connection with medical or surgical treatment of a covered illness or injury. Vision and hearing screening in connection with well-baby care is not excluded.

48. Prosthetic devices. Prostheses, except artificial limbs and eyes, or if an item is inserted surgically in the body as an integral part of a surgical procedure. All dental prostheses are excluded, except for those specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

49. Orthopedic shoes. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes, or regular shoes later built up.

50. Eyeglasses. Eyeglasses, spectacles, contact lenses, or other optical devices, except as specifically provided under subsection E.6. of this chapter.

51. Hearing aids. Hearing aids or other auditory sensory enhancing devices.

52. Telephonic services. Services or advice rendered by telephone or other telephonic device, including remote monitoring, except for transtelephonic monitoring of cardiac pacemakers.

53. Air conditioners, humidifiers, dehumidifiers, and purifiers.

54. Elevators or chair lifts.

55. Alterations. Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.

56. Clothing. Items of clothing or shoes, even if required by virtue of an allergy (such as cotton fabric as against synthetic fabric and vegetable dyed shoes).

57. Food, food substitutes. Food, food substitutes, vitamins, or other nutritional supplements, including those related to prenatal care.

58. Enuresis. Enuretic devices; enuretic conditioning programs.

59. RESERVED.

60. Autopsy and postmortem.

61. Camping. All camping even though organized for a specific therapeutic purpose (such as diabetic camp or a camp for emotionally disturbed children), and even though offered as a part of an otherwise covered treatment plan or offered through a CHAMPUS-approved facility.

62. Housekeeper, companion. Housekeeping, homemaker, or attendant services; sitter or companion.

63. Noncovered condition, unauthorized provider. All services and supplies (including inpatient institutional costs) related to a noncovered condition or treatment, or provided by an unauthorized provider.

64. Comfort or convenience. Personal, comfort, or convenience items such as beauty and barber services, radio, television, and telephone.

65. "Stop smoking" programs. Services and supplies related to "stop smoking" regimens.

66. Megavitamin psychiatric therapy, orthomolecular psychiatric therapy.

67. Transportation. All transportation except by ambulance, as specifically provided under section D. of this chapter, and except as authorized in subsection E.5. of this chapter.

68. Travel. All travel even though prescribed by a physician and even if its purpose is to obtain medical care, except as specified in subsection A.6. of this chapter in connection with a CHAMPUS-required physical examination.

69. Institutions. Services and supplies provided by other than a hospital, unless the institution has been approved specifically by OCHAMPUS. Nursing homes, intermediate care facilities, halfway houses, homes for the aged, or institutions of similar purpose are excluded from consideration as approved facilities under the Basic Program.

NOTE: In order to be approved under CHAMPUS, an institution must, in addition to meeting CHAMPUS standards, provide a level of care for which CHAMPUS benefits are payable.

70. Supplemental diagnostic services. Diagnostic services including clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results performed by civilian providers at the request of the attending Uniformed Service medical department physician (active duty or civil service).

71. Supplemental consultations. Consultations provided by civilian providers at the request of the attending Uniformed Services medical department physician (active duty or civil service).

72. Inpatient mental health services. Effective for care received on or after October 1, 1991, services in excess of 30 days in any fiscal year (or in an admission), in the case of a patient nineteen years of age or older, 45 days in any fiscal year (or in an admission) in the case of a patient under 19 years of age, or 150 days in any fiscal year (or in an admission) in the case of inpatient mental health services provided as residential treatment care, unless coverage for such services is granted by a waiver by the Director, OCHAMPUS, or a designee. In cases involving the day limitations, waivers shall be handled in accordance with paragraphs B.8. or B.9. of this chapter. For services prior to October 1, 1991, services in excess of 60 days in any calendar year unless additional coverage is granted by the Director, OCHAMPUS, or a designee.

73. Economic interest in connection with mental health admissions. Inpatient mental health services (including both acute care and RTC services) are excluded for care received when a patient is referred to a provider of such services by a physician (or other health care professional with authority to admit) who has an economic interest in the facility to which the patient is referred, unless a waiver is granted. Requests for waiver shall be considered under the same procedure and based on the same criteria as used for obtaining preadmission authorization (or continued stay authorization for

emergency admissions), with the only additional requirement being that the economic interest be disclosed as part of the request. The same reconsideration and appeals procedures that apply to day limit waivers shall also apply to decisions regarding requested waivers of the economic interest exclusion. However, a provider may appeal a reconsidered determination that an economic relationship constitutes an economic interest within the scope of the exclusion to the same extent that a provider may appeal determinations under paragraph I.3., Chapter 15. This exclusion does not apply to services under the Program for the Handicapped (Chapter 5 of this Regulation) or provided as partial hospital care. If a situation arises where a decision is made to exclude CHAMPUS payment solely on the basis of the provider's economic interest, the normal CHAMPUS appeals process will be available.

74. Not specifically listed. Services and supplies not specifically listed as a benefit in this Regulation. This exclusion is not intended to preclude extending benefits for those services or supplies specifically determined to be covered within the intent of this Regulation by the Director, OCHAMPUS, or a designee, even though not otherwise listed.

NOTE: The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not listed specifically as an exclusion.

H. Payment and liability for certain potentially excludable services under the Peer Review Organization program.

1. Applicability. This section provides special rules that apply only to services retrospectively determined under the Peer Review Organization (PRO) program (operated pursuant to Chapter 15) to be potentially excludable (in whole or in part) from the Basic Program under section G. of this chapter. Services may be excluded by reason of being not medically necessary (subsection G.1.) at an inappropriate level (subsection G.3.) custodial care (subsection G.7.) or other reason relative to reasonableness, necessity or appropriateness (which services shall throughout the remainder of this section, be referred to as "not medically necessary"). (Also throughout the remainder of the section, "services" includes items and "provider" includes supplier.) This section does not apply to coverage determinations made by OCHAMPUS or the fiscal intermediaries which are not based on medical necessity determinations made under the PRO program.

2. Payment for certain potentially excludable expenses. Services determined under the PRO program to be potentially excludable by reason of the exclusions in section G. of this chapter for not medically necessary services will not be determined to be excludable if neither the beneficiary to whom the services were provided nor the provider (institutional or individual) who furnished the services knew, or could reasonably have been expected to know, that the services were subject to those exclusions. Payment may be made for such services as if the exclusions did not apply.

3. Liability for certain excludable services. In any case in which items or services are determined excludable by the PRO program by reason of being not

medically necessary and payment may not be made under subsection H.2., above because the requirements of subsection H.2. are not met, the beneficiary may not be held liable (and shall be entitled to a full refund from the provider of the amount excluded and any cost-share amount already paid) if:

a. The beneficiary did not know and could not reasonably have been expected to know that the services were excludable by reason of being not medically necessary; and

b. The provider knew or could reasonably have been expected to know that the items or services were excludable by reason of being not medically necessary.

4. Criteria for determining that beneficiary knew or could reasonably have been expected to have known that services were excludable. A beneficiary who receives services excludable by reason of being not medically necessary will be found to have known that the services were excludable if the beneficiary has been given written notice that the services were excludable or that similar or comparable services provided on a previous occasion were excludable and that notice was given by the OCHAMPUS, CHAMPUS PRO or fiscal intermediary, a group or committee responsible for utilization review for the provider, or the provider who provided the services.

5. Criteria for determining that provider knew or could reasonably have been expected to have known that services were excludable. An institutional or individual provider will be found to have known or been reasonably expected to have known that services were excludable under this section under any one of the following circumstances:

a. The PRO or fiscal intermediary had informed the provider that the services provided were excludable or that similar or reasonably comparable services were excludable.

b. The utilization review group or committee for an institutional provider or the beneficiary's attending physician had informed the provider that the services provided were excludable.

c. The provider had informed the beneficiary that the services were excludable.

d. The provider had received written materials, including notices, manual issuances, bulletins, guides, directives, or other materials, providing notification of PRO screening criteria specific to the condition of the beneficiary. Attending physicians who are members of the medical staff of an institutional provider will be found to have also received written materials provided to the institutional provider.

e. The services that are at issue are the subject of what are generally considered acceptable standards of practice by the local medical community.

f. Preadmission authorization was available but not requested, or concurrent review requirements were not followed.

CHAPTER 6
AUTHORIZED PROVIDERS

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CHAPTER 6
AUTHORIZED PROVIDERS

A. GENERAL

This chapter sets forth general policies and procedures that are the basis for the CHAMPUS cost-sharing of medical services and supplies provided by institutions, individuals, or other types of providers. Providers seeking payment from the Federal Government through programs such as CHAMPUS have a duty to familiarize themselves with, and comply with, the program requirements.

1. Listing of provider does not guarantee payment of benefits. The fact that a type of provider is listed in this chapter is not to be construed to mean that CHAMPUS will automatically pay a claim for services or supplies provided by such a provider. The provider who actually furnishes the service(s) must, in fact, meet all licensing and other requirements established by this Regulation to be an authorized provider; the provider must not be the subject of sanction under Chapter 9; and, cost-sharing of the services must not otherwise be prohibited by this Regulation. In addition, the patient must in fact be an eligible beneficiary and the services or supplies billed must be authorized and medically necessary, regardless of the standing of the provider.

2. Outside the United States or emergency situations within the United States. Outside the United States or within the United States and Puerto Rico in emergency situations, the Director, OCHAMPUS, or a designee, after review of the facts, may provide payment to or on behalf of a beneficiary who receives otherwise covered services or supplies from a provider of service that does not meet the standards described in this Regulation.

NOTE: Only the Secretary of Defense, the Secretary of Health and Human Services, or the Secretary of Transportation, or their designees, may authorize (in emergency situations) payment to civilian facilities in the United States that are not in compliance with title VI of the Civil Rights Act of 1964 (reference (z)). For the purpose of the Civil Rights Act only, the United States includes the 50 states, the District of Columbia, Puerto Rico, Virgin Islands, American Samoa, Guam, Wake Island, Canal Zone, and the territories and possessions of the United States.

3. Dual compensation/conflict of interest. Title 5, United States Code, section 5536 (reference (bb)) prohibits medical personnel who are active duty Uniformed Service members or civilian employees of the Government from receiving additional Government compensation above their normal pay and allowances for medical care furnished. In addition, Uniformed Service members and civilian employees of the Government are generally prohibited by law and agency regulations and policies from participating in apparent or actual conflict of interest situations in which a potential for personal gain exists or in

which there is an appearance of impropriety or incompatibility with the performance of their official duties or responsibilities. The Departments of Defense, Health and Human Services, and Transportation have a responsibility, when disbursing appropriated funds in the payment of CHAMPUS benefits, to ensure that the laws and regulations are not violated. Therefore, active duty Uniformed Service members (including a reserve member while on active duty) and civilian employees of the United States Government shall not be authorized to be CHAMPUS providers. While individual employees of the Government may be able to demonstrate that the furnishing of care to CHAMPUS beneficiaries may not be incompatible with their official duties and responsibilities, the processing of millions of CHAMPUS claims each year does not enable Program administrators to efficiently review the status of the provider on each claim to ensure that no conflict of interest or dual compensation situation exists. The problem is further complicated given the numerous interagency agreements (for example, resource sharing arrangements between the Department of Defense and the Veterans Administration in the provision of health care) and other unique arrangements which exist at individual treatment facilities around the country. While an individual provider may be prevented from being an authorized CHAMPUS provider even though no conflict of interest or dual compensation situation exists, it is essential for CHAMPUS to have an easily administered, uniform rule which will ensure compliance with the existing laws and regulations. Therefore, a provider who is an active duty Uniformed Service member or civilian employee of the Government shall not be an authorized CHAMPUS provider. In addition, a provider shall certify on each CHAMPUS claim that he/she is not an active duty Uniformed Service member or civilian employee of the Government.

4. For-profit institutions excluded under the Program for the Handicapped (PFTH). 10 U.S.C. 1079(d)(4) (reference (a)) precludes payment of benefits under the PFTH for otherwise covered services and supplies provided by a for-profit institution (refer to Chapter 5 of this Regulation).

5. Utilization review and quality assurance. Providers approved as authorized CHAMPUS providers have certain obligations to provide services and supplies under CHAMPUS which are (i) furnished at the appropriate level and only when and to the extent medically necessary under the criteria of this Regulation; (ii) of a quality that meets professionally recognized standards of health care; and, (iii) supported by adequate medical documentation as may be reasonably required under this Regulation by the Director, OCHAMPUS, or a designee, to evidence the medical necessity and quality of services furnished, as well as the appropriateness of the level of care. Therefore, the authorization of CHAMPUS benefits is contingent upon the services and supplies furnished by any provider being subject to pre-payment or post-payment utilization and quality assurance review under professionally recognized standards, norms, and criteria, as well as any standards or criteria issued by the Director, OCHAMPUS, or a designee, pursuant to this Regulation. (Refer to Chapters 4, 5, and 7 of this Regulation.)

6. Exclusion of beneficiary liability. In connection with certain utilization review, quality assurance and preauthorization requirements of Chapter 4, providers may not hold patients liable for payment for certain services for which CHAMPUS payment is disallowed. With respect to such

services, providers may not seek payment from the patient or the patient's family. Any such effort to seek payment is a basis for termination of the provider's authorized status.

7. Provider required. In order to be considered for benefits, all services and supplies shall be rendered by, prescribed by, or furnished at the direction of, or on the order of a CHAMPUS-authorized provider practicing within the scope of his or her license.

8. Participating providers.

a. In general. A Participating Provider is an individual or institutional provider that has agreed to accept the CHAMPUS-determined allowable amount as payment in full for the medical services and supplies provided to the CHAMPUS beneficiary, and has agreed to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing and deductible amounts paid by, or on behalf of, the beneficiary as full payment for the covered medical services or supplies. In addition, Participating Providers submit the appropriate claims forms to the appropriate CHAMPUS contractor on behalf of the beneficiary. There are several circumstances under which providers are Participating Providers.

b. Mandatory participation Medicare-participating hospitals are required by law to be Participating Providers on all inpatient claims under CHAMPUS. Hospitals that are not Medicare-participating providers but are subject to the CHAMPUS DRG-based payment system or the CHAMPUS mental health payment system (see Chapter 14.A.), must sign agreements to participate on all CHAMPUS inpatient claims in order to be authorized providers under CHAMPUS.

c. Participating Provider Program.

(1) In general. An institutional provider not required to participate pursuant to paragraph A.8.b, of this chapter and any individual provider may become a Participating Provider by signing a Participating Provider agreement. In such an agreement, the provider agrees that all CHAMPUS claims filed during the time period covered by the agreement will be on a participating basis.

(2) Agreement required. Under the Participating Provider Program, the provider must sign an agreement or memorandum of understanding under which the provider agrees to become a Participating Provider. Such an agreement may be with the nearby military treatment facility, a CHAMPUS contractor, or other authorized official. Such an agreement may include other provisions pertaining to the Participating Provider Program. The Director, OCHAMPUS shall establish a standard model agreement and other procedures to promote uniformity in the administration of the Participating Provider Program.

(3) Relationship to other activities. Participating Provider agreements may include other provisions, such as provisions regarding discounts (see Chapter 14.1) or other provisions in connection with the delivery and financing of health care services, as authorized by this chapter or other DoD Directives or Instructions. Participating Provider agreement provisions may also be incorporated into other types of agreements, such as preferred provider

arrangements where such arrangements are established under CHAMPUS.

d. Claim-by-claim-participation. Institutional and individual providers that are not participating providers pursuant to paragraphs A.8.b., or c., of this chapter, may elect to participate on a claim-by-claim basis. They may do so by signing the appropriate space on the claims form and submitting it to the appropriate CHAMPUS contractor on behalf of the beneficiary.

9. Limitation to authorized institutional provider designation. Authorized institutional provider status granted to a specific institutional provider applicant does not extend to any institution-affiliated provider, as defined in Chapter 2 of this Regulation, of that specific applicant.

10. Authorized provider. A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized in this chapter to provide benefits under CHAMPUS. In addition, to be an authorized CHAMPUS provider, any hospital which is a CHAMPUS participating provider under Section A.7. of this chapter, shall be a participating provider for all care, services, or supplies furnished to an active duty member of the uniformed services for which the active duty member is entitled under title 10, United States Code, section 1074(c). As a participating provider for active duty members, the CHAMPUS authorized hospital shall provide such care, services, and supplies in accordance with the payment rules of Chapter 16. The failure of any CHAMPUS participating hospital to be a participating provider for any active duty member subjects the hospital to termination of the hospital's status as a CHAMPUS authorized provider for failure to meet the qualifications established by this chapter.

11. Submittal of claims by provider required.

a. General rule. Unless waived pursuant to paragraph A.11.b., of this chapter, every CHAMPUS-authorized institutional and individual provider is required to submit CHAMPUS claims to the appropriate CHAMPUS contractor on behalf of the beneficiary for all services and supplies. In addition, the provider may not impose any charge relating to completing and submitting the applicable claim form (or any other related information). (Although CHAMPUS encourages provider participation, this paragraph A.11., requires only the submission of claim forms by providers on behalf of beneficiaries; it does not require that providers accept assignment of beneficiaries' claims or become participating providers.)

b. Waiver of claims submission requirement. The requirement that providers submit claims on behalf of beneficiaries may be waived in circumstances set forth in this paragraph A.11.b. A decision by the Director, OCHAMPUS to waive or not to waive the requirement in any particular circumstance is not subject to the appeal and hearing procedures of Chapter 10 of this regulation.

(1) General requirement for waiver. The requirement that providers submit claims on behalf of beneficiaries may be waived by the Director, OCHAMPUS when the Director determines that the waiver is necessary in order to ensure adequate access for CHAMPUS beneficiaries to health care services. However, the requirement may not be waived for Participating Providers (see paragraph A.8., of this chapter).

(2) Blanket waiver for provider outside the United States. The requirement that providers submit claims is waived with respect to providers outside the United States (the United States includes Puerto Rico for this purpose).

(3) Blanket waiver in double coverage cases. The requirement that providers submit claims is waived in cases in which another insurance plan or program provides primary coverage for the services.

(4) Waivers for particular categories of care. The Director, OCHAMPUS may waive the requirement that providers submit claims if the Director determines that available evidence clearly shows that the requirement would impair adequate access. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the number of such providers who are CHAMPUS Participating Providers, the number of CHAMPUS beneficiaries in the area, and other relevant factors. Providers or beneficiaries in a locality may submit to the Director, OCHAMPUS a petition, together with appropriate documentation regarding relevant factors, for a determination that adequate access would be impaired. The Director, OCHAMPUS will consider and respond to all such petitions. The Director, OCHAMPUS may establish procedures for handling such petitions.

(5) Case-by-case waivers. On a case-by-case basis, the Director, OCHAMPUS may waive the provider's obligation to submit that claim if the Director determines that a waiver in that case is necessary in order to ensure adequate access for CHAMPUS beneficiaries to the health care services involved. Such case-by-case waivers may be requested by providers or beneficiaries pursuant to procedures established by the Director.

c. Remedies for noncompliance.

(1) In any case in which a provider fails to submit a claim, or charges an administrative fee for filing a claim (or any other related information), in violation of the requirements of this paragraph A.11., the amount that would otherwise be allowable for the claim shall be reduced by ten percent, unless the reduction is waived by the Director, OCHAMPUS based on special circumstances. The amount disallowed by such a reduction may not be billed to the patient (or the patient's sponsor or family).

(2) Repeated failures by a provider to comply with the requirements of this paragraph A.11., shall be considered abuse and/or fraud and grounds for exclusion or suspension of the provider under Chapter 9., of this regulation.

12. Balance billing limits.

a. In general. Individual providers who are not participation providers may not balance bill a beneficiary an amount which exceeds the applicable billing limit. The balance billing limit shall be the same percentage as the Medicare limiting charge percentage for nonparticipating physicians.

SUPPLEMENTARY

INFORMATION

"CHANGE IN STATUS OF DOCUMENT"

11/09/95 7:27 AM

TO:DTIC/OMS

FROM:DTIC/OCC

SUBJECT:ERRATAS

BY: *Deborah Campbell*

DOCUMENT DESCRIPTIONS: (AD NUMBERS)

AD-A268 034 WHICH INCLUDES CHANGES #8 DTD 15 FEB 95 & CHANGE #9 DTD 22 MAR 95, WHICH INCLUDE INSTRUCTIONAL MEMOS & NEW OR REVISED PAGES.

AD-A278 040 CHANGE #1 WHICH IS A INSTRUCTIONAL MEMO DTD 1 JULY 95, PLUS NEW OR REVISED PAGES.

AD-A278 163 WHICH INCLUDES AN SEPARATE ERRATA SHEET, PLUS CHANGES #5 DTD 1 APR 95 & CHANGE #6 DTD 1 JUL 95, WHICH INCLUDE INSTRUCTIONAL MEMOS AND NEW OR REVISED PAGES.

AD-A278 357 WHICH INCLUDES CHANGE #1 DTD 1 JUL 95, CHANGE #4 DTD 1 APR 95 & CHANGE #5 DTD 1 JUL 95 WHICH A INSTRUCTIONAL MEMOS PLUS NEW OR REVISED PAGES.

AD-A278 457 WHICH IS AN INSTRUCTIONAL MEMO DTD 18 MAY 95, PLUS REVISED PAGES.

AD-A278 626 CHANGE #2 WHICH IS A INSTRUCTIONAL MEMO DTD 1 MAY 95, PLUS REVISED PAGES.

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AD-A279 259 FACSIMILE TRANSMITTAL SHEET DTD 24 OCT 95.

AD-A279 301 CHANGE #4 WHICH INCLUDES A INSTRUCTIONAL MEMO DTD 7 MAR 95, PLUS NEW OR REVISED PAGES.

AD-A279 353 CHANGE #3 WHICH INCLUDES A INSTRUCTIONAL MEMO DTD 22 MAY 95, PLUS NEW OR REVISED PAGES

"CHANGE IN STATUS OF DOCUMENT"

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AD-B969 460 WHICH INCLUDES AN BIENNIAL REVIEW MEMO DTD 6 SEP 95 & A DD FORM 2024.

AD-B175 934 WHICH INCLUDES AN BIENNIAL REVIEW MEMO DTD 6 SEP 95 & A DD FORM 2024.

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February 15, 1995

CIVILIAN HEALTH AND MEDICAL PROGRAM
OF THE UNIFORMED SERVICES (CHAMPUS)

Change 8.

The Assistant Secretary of Defense for Health Affairs has authorized the following change to DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," July 1991 (Reprint).

PAGE CHANGE

Remove: Pages vii, 2-iii through 2-v, 2-13 through 2-26, 4-v through 4-ix, 4-42a through 4-55, 6-i&6-ii, 6-23 through 6-33, 14-i&14-ii, and 14-21 through 14-28

Insert: Attached replacement pages and new pages 2-27, 4-56 through 4-67, 6-34 through 6-36, 14-29 through 14-34, and 20-i through 20-7

Changes appear on pages vii, 2-iii through 2-v, 2-14, 2-25, 4-vi through 4-ix, 4-43 through 4-50, 6-ii, 6-25&6-26, 14-i&14-ii, 14-21 through 14-26, and 14-32 through 14-34

EFFECTIVE DATE

The above changes for Continued Health Care Benefit Program are effective immediately. Hospice Benefit changes are effective June 1, 1995.

B.C. Whitehead

B.C. WHITEHEAD
Director
Correspondence and Directives

Attachments
89 pages

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, THIS TRANSMITTAL SHOULD BE FILED WITH THE BASIC DOCUMENT

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be covered under CHAMPUS as if FDA approved. Certain cancer drugs, designated as Group C drugs (approved and distributed by the National Cancer Institute) and Treatment Investigational New Drugs (INDs), cannot be cost-shared under CHAMPUS because they are not approved for commercial marketing by the FDA. However, medical care related to the use of Group C drugs and Treatment INDs can be cost-shared under CHAMPUS when the patient's medical condition warrants their administration and the care is provided in accordance with generally accepted standards of medical practice. NOTE: In areas outside the United States, standards comparable to those of the FDA are the CHAMPUS objective.

External Partnership Agreement. The external partnership agreement is an agreement between a military treatment facility commander and a CHAMPUS authorized institutional provider, enabling Uniformed Services health care personnel to provide otherwise covered medical care to CHAMPUS beneficiaries in a civilian facility under the Military-Civilian Health Services Partnership Program. Authorized costs associated with the use of the facility will be financed through CHAMPUS under normal cost-sharing and reimbursement procedures currently applicable under the basic CHAMPUS.

Extramedical Individual Providers of Care. Individuals who do counseling or nonmedical therapy and whose training and therapeutic concepts are outside the medical field, as specified in Chapter 6 of this Regulation.

Fraud. For purposes of this Regulation, fraud is defined as 1) a deception or misrepresentation by a provider, beneficiary, sponsor, or any person acting on behalf of a provider, sponsor, or beneficiary with the knowledge (or who had reason to know or should have known) that the deception or misrepresentation could result in some unauthorized CHAMPUS benefit to self or some other person, or some unauthorized CHAMPUS payment, or 2) a claim that is false or fictitious, or includes or is supported by any written statement which asserts a material fact which is false or fictitious, or includes or is supported by any written statement that (a) omits a material fact and (b) is false or fictitious as a result of such omission and (c) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact. It is presumed that, if a deception or misrepresentation is established and a CHAMPUS claim is filed, the person responsible for the claim had the requisite knowledge. This presumption is rebuttable only by substantial evidence. It is further presumed that the provider of the services is responsible for the actions of all individuals who file a claim on behalf of the provider (for example, billing clerks); this presumption may only be rebutted by clear and convincing evidence.

Freestanding. Not "institution-affiliated" or "institution-based."

Former Spouse. A former husband or wife of a Uniformed Service member or former member who meets the criteria as set forth in paragraph B.2.b. of Chapter 3 of this Regulation.

Full-Time Course of Higher Education. A complete, progressive series of studies to develop attributes such as knowledge, skill, mind, and character, by formal schooling at a college or university, and which meets the criteria set out in Chapter 3 of this Regulation. To qualify as full-time, the student must be carrying a course load of a minimum of 12 credit hours or equivalent each semester.

General Staff Nursing Service. All nursing care (other than that provided by private duty nurses) including, but not limited to, general duty nursing, emergency room nursing, recovery room nursing, intensive nursing care, and group nursing arrangements performed by nursing personnel on the payroll of the hospital or other authorized institution.

Good Faith Payments. Those payments made to civilian sources of medical care who provided medical care to persons purporting to be eligible beneficiaries but who are determined later to be ineligible for CHAMPUS benefits. (The ineligible person usually possesses an erroneous or illegal identification card.) To be considered for good faith payments, the civilian source of care must have exercised reasonable precautions in identifying a person claiming to be an eligible beneficiary.

High-risk pregnancy. A pregnancy is high-risk when the presence of a currently active or previously treated medical, anatomical, physiological illness or condition may create or increase the likelihood of a detrimental effect on the mother, fetus, or newborn and presents a reasonable possibility of the development of complications during labor or delivery.

Hospice care. Hospice care is a program which provides an integrated set of services and supplies designed to care for the terminally ill. This type of care emphasizes palliative care and supportive services, such as pain control and home care, rather than cure-oriented services provided in institutions that are otherwise the primary focus under CHAMPUS. The benefit provides coverage for a humane and sensible approach to care during the last days of life for some terminally ill patients.

Hospital, Acute Care (General and Special). An institution that meets the criteria as set forth in paragraph B.4.a. of Chapter 6 of this Regulation.

Hospital, Long-Term (Tuberculosis, Chronic Care, or Rehabilitation). An institution that meets the criteria as set forth in paragraph B.4. of Chapter 6 of this Regulation.

Hospital, Psychiatric. An institution that meets the criteria as set forth in paragraph B.4. of Chapter 6 of this Regulation.

Illegitimate Child. A child not recognized as a lawful offspring; that is, a child born of parents not married to each other.

Immediate Family. The spouse, natural parent, child and sibling, adopted child and adoptive parent, stepparent, stepchild, grandparent, grandchild, stepbrother and stepsister, father-in-law, mother-in-law of the beneficiary, or provider, as appropriate. For purposes of this definition only, to determine who may render services to a beneficiary, the step-relationship continues to exist even if the marriage upon which the relationship is based terminates through divorce or death of one of the parents.

Independent Laboratory. A freestanding laboratory approved for participation under Medicare and certified by the Health Care Financing Administration.

Infirmaries. Facilities operated by student health departments of colleges and universities to provide inpatient or outpatient care to enrolled students. When specifically approved by the Director, OCHAMPUS, or a designee, a boarding school infirmary also is included.

Initial Determination. A formal written decision on a CHAMPUS claim, a request for benefit authorization, a request by a provider for approval as an authorized CHAMPUS provider, or a decision disqualifying or excluding a provider as an authorized provider under CHAMPUS. Rejection of a claim or a request for benefit or provider authorization for failure to comply with administrative requirements, including failure to submit reasonably requested information, is not an initial determination. Responses to general or specific inquiries regarding CHAMPUS benefits are not initial determinations.

In-Out Surgery. Surgery performed in the outpatient department of a hospital or other institutional provider, in a physician's office or the office of another individual professional provider, in a clinic, or in a "freestanding" ambulatory surgical center which does not involve a formal inpatient admission for a period of 24 hours or more.

Inpatient. A patient who has been admitted to a hospital or other authorized institution for bed occupancy for purposes of receiving necessary medical care, with the reasonable expectation that the patient will remain in the institution at least 24 hours, and with the registration and assignment of an inpatient number or designation. Institutional care in connection with in and out (ambulatory) surgery is not included within the meaning of inpatient whether or not an inpatient number or designation is made by the hospital or other institution. If the patient has been received at the hospital, but death occurs before the actual admission occurs, an inpatient admission exists as if the patient had lived and had been formally admitted.

Institution-Affiliated. Related to a CHAMPUS authorized institutional provider through a shared governing body but operating under a separate and distinct license or accreditation.

Institution-Based. Related to a CHAMPUS authorized institutional provider through a shared governing body and operating under a common license and shared accreditation.

Institutional Provider. A health care provider which meets the applicable requirements established by section B. of Chapter 6 of this Regulation.

Intensive Care Unit (ICU). A special segregated unit of a hospital in which patients are concentrated by reason of serious illness, usually without regard to diagnosis. Special lifesaving techniques and equipment regularly and immediately are available within the unit, and patients are under

continuous observation by a nursing staff specially trained and selected for the care of this type patient. The unit is maintained on a continuing rather than an intermittent or temporary basis. It is not a postoperative recovery room nor a postanesthesia room. In some large or highly specialized hospitals, the ICUs may be further refined for special purposes, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery. For the purposes of CHAMPUS, these specialized units would be considered ICUs if they otherwise conformed to the definition of an ICU.

Intern. A graduate of a medical or dental school serving in a hospital in preparation to being licensed to practice medicine or dentistry.

Internal Partnership Agreement. The internal partnership agreement is an agreement between a military treatment facility commander and a CHAMPUS authorized civilian health care provider which enables the use of civilian health care personnel or other resources to provide medical care to CHAMPUS beneficiaries on the premises of a military treatment facility under the Military-Civilian Health Services Partnership Program. These internal agreements may be established when a military treatment facility is unable to provide sufficient health care services for CHAMPUS beneficiaries due to shortages of personnel and other required resources.

Item, Service, or Supply. Includes (1) any item, device, medical supply, or service claimed to have been provided to a beneficiary (patient) and listed in an itemized claim for CHAMPUS payment or a request for payment, or (2) in the case of a claim based on costs, any entry or omission in a cost report, books of account, or other documents supporting the claim.

Laboratory and Pathological Services. Laboratory and pathological examinations (including machine diagnostic tests that produce hard-copy results) when necessary to, and rendered in connection with medical, obstetrical, or surgical diagnosis or treatment of an illness or injury, or in connection with well-baby care.

Legitimized Child. A formerly illegitimate child who is considered legitimate by reason of qualifying actions recognized in law.

Licensed Practical Nurse (L.P.N.). A person who is prepared specially in the scientific basis of nursing; who is a graduate of a school of practical nursing; whose qualifications have been examined by a state board of nursing; and who has been authorized legally to practice as an L.P.N. under the supervision of a physician.

Licensed Vocational Nurse (L.V.N.). A person who specifically is prepared in the scientific basis of nursing; who is a graduate of a school of vocational nursing; whose qualifications have been examined by a state board of nursing; and who has been authorized legally to practice as a L.V.N. under the supervision of a physician.

Long-Term Hospital Care. Any inpatient hospital stay that exceeds 30 days.

Low-Risk Pregnancy. A pregnancy is low-risk when the basis for the ongoing clinical expectation of a normal uncomplicated birth, as defined by reasonable and generally accepted criteria of maternal and fetal health, is documented throughout a generally accepted course of prenatal care.

Management Plan. A detailed description of the medical history of and proposed therapy for a CHAMPUS beneficiary seeking benefits under the PFTH as set forth in Chapter 5 of this Regulation. A management plan must include, at a minimum, a diagnosis (either in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) or the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III)); detailed reports of prior treatment, family history, social history, history of handicapping condition, and physical examination; diagnostic test results; consultants (if any) reports; proposed therapeutic approach and modality (including anticipated length of time the proposed modality will be required); prognosis; problem list; and all inclusive current or anticipated monthly charges related to the proposed management plan. If the management plan involves the transfer of a beneficiary from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the management plan documentation.

Marriage and Family Therapist, Certified. An extramedical individual provider who meets the requirements outlined in Chapter 6 of the Regulation.

Maternity Care. Care and treatment related to conception, delivery, and abortion, including prenatal and postnatal care (generally through the 6th post-delivery week), and also including treatment of the complications of pregnancy.

Medicaid. Those medical benefits authorized under Title XIX of the Social Security Act (reference (h)) provided to welfare recipients and the medically indigent through programs administered by the various states.

Medical. The generally used term which pertains to the diagnosis and treatment of illness, injury, pregnancy, and mental disorders by trained and licensed or certified health professionals. For purposes of CHAMPUS, the term "medical" should be understood to include "medical, psychological, surgical, and obstetrical," unless it is specifically stated that a more restrictive meaning is intended.

Medical Emergency. The sudden and unexpected onset of a medical condition or the acute exacerbation of a chronic condition that is threatening to life, limb, or sight, and requires immediate medical treatment or which manifests painful symptomatology requiring immediate palliative efforts to alleviate suffering. Medical emergencies include heart attacks, cardiovascular accidents, poisoning, convulsions, kidney stones, and such other acute medical conditions as may be determined to be medical emergencies by the Director, OCHAMPUS, or a designee. In the case of a pregnancy, a medical emergency must involve a sudden and unexpected medical complication that puts the mother, the baby, or both, at risk. Pain would not, however,

qualify a maternity case as an emergency, nor would incipient birth after the 34th week of gestation, unless an otherwise qualifying medical condition is present. Examples of medical emergencies related to pregnancy or delivery are hemorrhage, ruptured membrane with prolapsed cord, placenta previa, abruptio placenta, presence of shock or unconsciousness, suspected heart attack or stroke, or trauma (such as injuries received in an automobile accident).

Medically or Psychologically Necessary. The frequency, extent, and types of medical services or supplies which represent appropriate medical care and that are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, and mental disorders or that are reasonable and adequate for well-baby care.

Medical Supplies and Dressings (Consumables). Necessary medical or surgical supplies (exclusive of durable medical equipment) that do not withstand prolonged, repeated use and that are needed for the proper medical management of a condition for which benefits are otherwise authorized under CHAMPUS, on either an inpatient or outpatient basis. Examples include disposable syringes for a diabetic, colostomy sets, irrigation sets, and ace bandages.

Medicare. Those medical benefits authorized under Title XVIII of the Social Security Act (reference (h)) provided to persons 65 or older, certain disabled persons, or persons with chronic renal disease, through a national program administered by the DHHS, Health Care Financing Administration, Medicare Bureau.

Mental Disorder. For purposes of the payment of CHAMPUS benefits, a mental disorder is a nervous or mental condition that involves a clinically significant behavioral or psychological syndrome or pattern that is associated with a painful symptom, such as distress, and that impairs a patient's ability to function in one or more major life activities. Additionally, the mental disorder must be one of those conditions listed in the DSM-III.

Mental Health Counselor. An extramedical individual provider who meets the requirements outlined in Chapter 6 of this Regulation.

Mental Health Therapeutic Absence. A therapeutically planned absence from the inpatient setting. The patient is not discharged from the facility and may be away for periods of several hours to several days. The purpose of the therapeutic absence is to give the patient an opportunity to test his or her ability to function outside the inpatient setting before the actual discharge.

Mental Retardation. Subnormal general intellectual functioning associated with impairment of either learning and social adjustment or maturation, or both. The diagnostic classification of moderate and severe mental retardation relates to intelligence quotient (IQ) as follows:

1. Moderate. Moderate mental retardation IQ 36-51.
2. Severe. Severe mental retardation IQ 35 and under.

Missing in Action (MIA). A battle casualty whose whereabouts and status are unknown, provided the absence appears to be involuntary and the service member is not known to be in a status of unauthorized absence. NOTE: Claims for eligible CHAMPUS beneficiaries whose sponsor is classified as MIA are processed as dependents of an active duty service member.

Morbid Obesity. The body weight is 100 pounds over ideal weight for height and bone structure, according to the most current Metropolitan Life Table, and such weight is in association with severe medical conditions known to have higher mortality rates in association with morbid obesity; or, the body weight is 200 percent or more of the ideal weight for height and bone structure according to the most current Metropolitan Life Table. The associated medical conditions are diabetes mellitus, hypertension, cholecystitis, narcolepsy, pickwickian syndrome (and other severe respiratory diseases), hypothalamic disorders, and severe arthritis of the weight-bearing joints.

Most-Favored Rate. The lowest usual charge to any individual or third-party payer in effect on the date of the admission of a CHAMPUS beneficiary.

Natural Childbirth. Childbirth without the use of chemical induction or augmentation of labor or surgical procedures other than episiotomy or perineal repair.

Naturopath. A person who practices naturopathy, that is, a drugless system of therapy making use of physical forces such as air, light, water, heat, and massage. NOTE: Services of a naturopath are not covered by CHAMPUS.

Nonavailability Statement. A certification by a commander (or a designee) of a Uniformed Services medical treatment facility recorded on DD Form 1251, generally for the reason that the needed medical care being requested by a CHAMPUS beneficiary cannot be provided at the facility concerned because the necessary resources are not available.

Nonparticipating Provider. A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished medical services or supplies to a CHAMPUS beneficiary, but who did not agree on the CHAMPUS claim form to participate or to accept the CHAMPUS-determined allowable cost or charge as the total charge for the services. A nonparticipating provider looks to the beneficiary or sponsor for payment of his or her charge, not CHAMPUS. In such cases, CHAMPUS pays the beneficiary or sponsor, not the provider.

North Atlantic Treaty Organization (NATO) Member. A military member of an armed force of a foreign NATO nation who is on active duty and who, in connection with official duties, is stationed in or passing through the United States. The foreign NATO nations are Belgium, Canada, Denmark, France, Federal Republic of Germany, Greece, Iceland, Italy, Luxemburg, the Netherlands, Norway, Portugal, Spain, Turkey, and the United Kingdom.

Official Formularies. A book of official standards for certain pharmaceuticals and preparations that are not included in the U.S. Pharmacopeia.

Optometrist (Doctor of Optometry). A person trained and licensed to examine and test the eyes and to treat visual defects by prescribing and adapting corrective lenses and other optical aids, and by establishing programs of exercises.

Oral Surgeon (D.D.S. or D.M.D.). A person who has received a degree in dentistry and who limits his or her practice to oral surgery, that is, that branch of the healing arts that deals with the diagnosis and the surgical correction and adjunctive treatment of diseases, injuries, and defects of the mouth, the jaws, and associated structures.

Orthopedic Shoes. Shoes prescribed by an orthopedic surgeon to effect changes in foot or feet position and alignment and which are not an integral part of a brace.

Other Allied Health Professionals. Individual professional providers other than physicians, dentists, or extramedical individual providers, as specified in Chapter 6 of this Regulation.

Other Special Institutional Providers. Certain special institutional providers, either inpatient or outpatient, other than those specifically defined, that provide courses of treatment prescribed by a doctor of medicine or osteopathy; when the patient is under the supervision of a doctor of medicine or osteopathy during the entire course of the inpatient admission or the outpatient treatment; when the type and level of care and services rendered by the institution are otherwise authorized in this Regulation; when the facility meets all licensing or other certification requirements that are extant in the jurisdiction in which the facility is located geographically; which is accredited by the Joint Commission on Accreditation if an appropriate accreditation program for the given type of facility is available; and which is not a nursing home, intermediate facility, halfway house, home for the aged, or other institution of similar purpose.

Outpatient. A patient who has not been admitted to a hospital or other authorized institution as an inpatient.

Ownership or Control Interest. For purposes of Chapter 9.F.1., a "person with an ownership or control interest" is anyone who

1. Has directly or indirectly a 5 percent or more ownership interest in the entity; or
2. Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 percent of the total property and assets of the entity; or

3. Is an officer or director of the entity if the entity is organized as a corporation; or

4. Is a partner in the entity if the entity is organized as a partnership.

Partial Hospitalization. A treatment setting capable of providing an interdisciplinary program of medical therapeutic services at least 3 hours per day, 5 days per week, which may embrace day, evening, night and weekend treatment programs which employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. Partial hospitalization is a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic environment. Partial hospitalization is an appropriate setting for crisis stabilization, treatment of partially stabilized mental health disorders, and a transition from an inpatient program when medically necessary. Such programs must enter into a participation agreement with CHAMPUS, and be accredited and in substantial compliance with the standards of the Mental Health Manual of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (formerly known as the Consolidated Standards).

Participating Provider. A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished services or supplies to a CHAMPUS beneficiary and that submits a CHAMPUS claim form and accepts assignment of the CHAMPUS determined allowable cost or charge as the total payment (even though less than the actual charge), whether paid for fully by the CHAMPUS allowable amount or requiring cost-sharing by the beneficiary (or sponsor). See Chapter 6.A.8. for more information on the Participating Provider.

Party to a Hearing. An appealing party or parties and CHAMPUS.

Party to the Initial Determination. Includes CHAMPUS and also refers to a CHAMPUS beneficiary and a participating provider of services whose interests have been adjudicated by the initial determination. In addition, a provider who has been denied approval as an authorized CHAMPUS provider is a party to that initial determination, as is a provider who is disqualified or excluded as an authorized provider under CHAMPUS, unless the provider is excluded based on a determination of abuse or fraudulent practices or procedures under another federal or federally funded program. See Chapter 10 for additional information concerning parties not entitled to administrative review under the CHAMPUS appeals and hearing procedures.

Pastoral Counselor. An extramedical individual provider who meets the requirements outlined in Chapter 6 of the Regulation.

Pharmacist. A person who is trained specially in the scientific basis of pharmacology and who is licensed to prepare and sell or dispense drugs and compounds and to make up prescriptions ordered by a physician.

Physical Medicine Services or Physiatry Services. The treatment of disease or injury by physical means such as massage, hydrotherapy, or heat.

Physical Handicap. A physical condition of the body that meets the following criteria:

1. Duration. The condition is expected to result in death, or has lasted, or with reasonable certainty is expected to last, for a minimum period of 12 months, and

2. Extent. The condition is of such severity as to preclude the individual from engaging in substantially basic productive activities of daily living expected of unimpaired persons of the same age group.

Physical Therapist. A person who is trained specially in the skills and techniques of physical therapy (that is, the treatment of disease by physical agents and methods such as heat, massage, manipulation, therapeutic exercise, hydrotherapy, and various forms of energy such as electrotherapy and ultrasound), who has been authorized legally (that is, registered) to administer treatments prescribed by a physician and who is entitled legally to use the designation "Registered Physical Therapist." A physical therapist also may be called a physiotherapist.

Physician. A person with a degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is licensed to practice medicine by an appropriate authority.

Physician in Training. Interns, residents, and fellows participating in approved postgraduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital or other institutional provider setting, e.g., individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools.

Podiatrist (Doctor of Podiatry or Surgical Chiropody). A person who has received a degree in podiatry (formerly called chiropody), that is, that specialized field of the healing arts that deals with the study and care of the foot, including its anatomy, pathology, and medical and surgical treatment.

Preauthorization. A decision issued in writing by the Director, OCHAMPUS, or a designee, that CHAMPUS benefits are payable for certain services that a beneficiary has not yet received.

Prescription Drugs and Medicines. Drugs and medicines which at the time of use were approved for commercial marketing by the U.S. Food and Drug Administration, and which, by law of the United States, require a physician's or dentist's prescription, except that it includes insulin for known diabetics whether or not a prescription is required. Drugs grandfathered by the Federal Food, Drug and Cosmetic Act of 1938 may be covered under CHAMPUS as if FDA approved.

NOTE: The fact that the U.S. Food and Drug Administration has approved a drug for testing on humans would not qualify it within this definition.

Preventive Care. Diagnostic and other medical procedures not related directly to a specific illness, injury, or definitive set of symptoms, or obstetrical care, but rather performed as periodic health screening, health assessment, or health maintenance.

Primary Payer. The plan or program whose medical benefits are payable first in a double coverage situation.

Private Duty (Special) Nursing Services. Skilled nursing services rendered to an individual patient requiring intensive medical care. Such private duty (special) nursing must be by an actively practicing registered nurse (R.N.) or licensed practical or vocational nurse (L.P.N. or L.V.N.) only when the medical condition of the patient requires intensive skilled nursing services (rather than primarily providing the essentials of daily living) and when such skilled nursing care is ordered by the attending physician.

Private Room. A room with one bed that is designated as a private room by the hospital or other authorized institutional provider.

Program for the Handicapped (PFTH). The special program set forth in Chapter 5 of this Regulation, through which dependents of active duty members receive supplemental benefits for the moderately or severely mentally retarded and the seriously physically handicapped over and above those medical benefits available under the Basic Program.

Progress notes. Progress notes are an essential component of the medical record wherein health care personnel provide written evidence of ordered and supervised diagnostic tests, treatments, medical procedures, therapeutic behavior and outcomes. In the case of mental health care, progress notes must include: the date of the therapy session; length of the therapy session; a notation of the patient's signs and symptoms; the issues, pathology and specific behaviors addressed in the therapy session; a statement summarizing the therapeutic interventions attempted during the therapy session; descriptions of the response to treatment, the outcome of the treatment, and the response to significant others; and a statement summarizing the patient's degree of progress toward the treatment goals. Progress notes do not need to repeat all that was said during a therapy session but must document a patient contact and be sufficiently detailed to allow for both peer review and audits to substantiate the quality and quantity of care rendered.

Prosthetic Device (Prosthesis). An artificial substitute for a missing body part.

Provider. A hospital or other institutional provider, a physician, or other individual professional provider, or other provider of services or supplies as specified in Chapter 6 of this Regulation.

Provider Exclusion and Suspension. The terms "exclusion" and "suspension", when referring to a provider under CHAMPUS, both mean the denial of status as an authorized provider, resulting in items, services, or supplies furnished by the provider not being reimbursed, directly or indirectly, under CHAMPUS. The terms may be used interchangeably to refer to a provider who has been denied status as an authorized CHAMPUS provider based on 1) a criminal conviction or civil judgment involving fraud, 2) an administrative finding of fraud or abuse under CHAMPUS, 3) an administrative finding that the provider has been excluded or suspended by another agency of the Federal Government, a state, or a local licensing authority, 4) an administrative finding that the provider has knowingly participated in a conflict of interest situation, or 5) an administrative finding that it is in the best interests of the CHAMPUS or CHAMPUS beneficiaries to exclude or suspend the provider.

Provider Termination. When a provider's status as an authorized CHAMPUS provider is ended, other than through exclusion or suspension, based on a finding that the provider does not meet the qualifications, as set forth in Chapter 6 of this Regulation, to be an authorized CHAMPUS provider.

Psychiatric Emergency. A psychiatric inpatient admission is an emergency when, based on a psychiatric evaluation performed by a physician (or other qualified mental health care professional with hospital admission authority), the patient is at immediate risk of serious harm to self or others as a result of a mental disorder and requires immediate continuous skilled observation at the acute level of care.

Radiation Therapy Services. The treatment of diseases by x-ray, radium, or radioactive isotopes when ordered by the attending physician.

Referral. The act or an instance of referring a CHAMPUS beneficiary to another authorized provider to obtain necessary medical treatment. Under CHAMPUS, only a physician may make referrals.

Registered Nurse. A person who is prepared specially in the scientific basis of nursing, who is a graduate of a school of nursing, and who is registered for practice after examination by a state board of nurse examiners or similar regulatory authority, who holds a current, valid license, and who is entitled legally to use the designation R.N.

Representative. Any person who has been appointed by a party to the initial determination as counsel or advisor and who is otherwise eligible to serve as the counsel or advisor of the party to the initial determination, particularly in connection with a hearing.

Resident (Medical). A graduate physician or dentist who has an M.D. or D.O. degree, or D.D.S. or D.M.D. degree, respectively, is licensed to practice, and who chooses to remain on the house staff of a hospital to get further training that will qualify him or her for a medical or dental specialty.

Residential Treatment Center (RTC). A facility (or distinct part of a facility) which meets the criteria in Chapter 6.B.4.

Respite care. Respite care is short-term care for a patient in order to provide rest and change for those who have been caring for the patient at home, usually the patient's family.

Retiree. A member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay based on duty in a Uniformed Service.

Routine Eye Examinations. The services rendered in order to determine the refractive state of the eyes.

Sanction. For purpose of Chapter 9, "sanction" means a provider exclusion, suspension, or termination.

Secondary Payer. The plan or program whose medical benefits are payable in double coverage situations only after the primary payer has adjudicated the claim.

Semiprivate Room. A room containing at least two beds. If a room is designated publicly as a semiprivate accommodation by the hospital or other authorized institutional provider and contains multiple beds, it qualifies as a semiprivate room for the purposes of CHAMPUS.

Skilled Nursing Facility. An institution (or a distinct part of an institution) that meets the criteria as set forth in subsection B.4. of Chapter 6 of this Regulation.

Skilled Nursing Service. A service that can only be furnished by an R.N., or L.P.N. or L.V.N., and is required to be performed under the supervision of a physician to ensure the safety of the patient and achieve the medically desired result. Examples of skilled nursing services are intravenous or intramuscular injections, levin tube or gastrostomy feedings, or tracheotomy aspiration and insertion. Skilled nursing services are other than those services that provide primarily support for the essentials of daily living or that could be performed by an untrained adult with minimum instruction or supervision.

Specialized Treatment Service Facility. A military or civilian medical treatment facility specifically designated pursuant to Chapter 4, paragraph A.10, to be a referral facility for certain highly specialized care. For this purpose, a civilian medical treatment facility may be another federal facility (such as a Department of Veterans Affairs hospital).

Special Tutoring. Teaching or instruction provided by a private teacher to an individual usually in a private or separate setting to enhance the educational development of an individual in one or more study areas.

Spectacles, Eyeglasses, and Lenses. Lenses, including contact lenses, that help to correct faulty vision.

Sponsor. An active duty member, retiree, or deceased active duty member or retiree, of a Uniformed Service upon whose status his or her dependents' eligibility for CHAMPUS is based.

Spouse. A lawful wife or husband regardless of whether or not dependent upon the active duty member or retiree.

Student Status. A dependent of a member or former member of a Uniformed Service who has not passed his or her 23rd birthday, and is enrolled in a full-time course of study in an institution of higher learning.

Suppliers of Portable X-Ray Services. A supplier that meets the conditions of coverage of the Medicare program, set forth in the Medicare regulations (reference (m)), or the Medicaid program in the state in which the covered service is provided.

Surgery. Medically appropriate operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and those certain procedures listed in paragraph C.2.a. of Chapter 4 of this Regulation.

Surgical Assistant. A physician (or dentist or podiatrist) who assists the operating surgeon in the performance of a covered surgical service when such assistance is certified as necessary by the attending surgeon, when the type of surgical procedure being performed is of such complexity and seriousness as to require a surgical assistant, and when interns, residents, or other house staff are not available to provide the surgical assistance services in the specialty area required.

Suspension of Claims Processing. The temporary suspension of processing (to protect the government's interests) of claims for care furnished by a specific provider (whether the claims are submitted by the provider or beneficiary) or claims submitted by or on behalf of a specific CHAMPUS beneficiary pending action by the Director, OCHAMPUS, or a designee, in a case of suspected fraud or abuse. The action may include the administrative remedies provided for in Chapter 9 or any other Department of Defense issuance (e.g. DoD issuances implementing the Program Fraud Civil Remedies Act), case development or investigation by OCHAMPUS, or referral to the Department of Defense-Inspector General or the Department of Justice for action within their cognizant jurisdictions.

Teaching Physician. A teaching physician is any physician whose duties include providing medical training to physicians in training within a hospital or other institutional provider setting.

Timely Filing. The filing of CHAMPUS claims within the prescribed time limits as set forth in Chapter 7 of this Regulation.

Treatment Plan. A detailed description of the medical care being rendered or expected to be rendered a CHAMPUS beneficiary seeking approval for inpatient benefits for which preauthorization is required as set forth in section B. of Chapter 4 of this Regulation. A treatment plan must include, at a minimum, a diagnosis (either ICD-9-CM or DSM-III); detailed reports of prior treatment, medical history, family history, social history, and physical examination; diagnostic test results; consultant's reports (if any); proposed treatment by type (such as surgical, medical, and psychiatric); a description of who is or will be providing treatment (by discipline or specialty); anticipated frequency, medications, and specific goals of treatment; type of inpatient facility required and why (including length of time the related inpatient stay will be required); and prognosis. If the treatment plan involves the transfer of a CHAMPUS patient from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the treatment plan documentation.

Uniformed Services. The Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA.

Veteran. A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

NOTE: Unless the veteran is eligible for "retired pay," "retirement pay," or "retainer pay," which refers to payments of a continuing nature and are payable at fixed intervals from the government for military service neither the veteran nor his or her dependents are eligible for benefits under CHAMPUS.

Well-Baby Care. A specific program of periodic health screening, developmental assessment, and routine immunization for children from birth up to 2 years.

Widow or Widower. A person who was a spouse at the time of death of the active duty member or retiree and who has not remarried.

Worker's Compensation Benefits. Medical benefits available under any worker's compensation law (including the Federal Employees Compensation Act), occupational disease law, employers liability law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure.

X-Ray Services. An x-ray examination from which an x-ray film or other image is produced, ordered by the attending physician when necessary and rendered in connection with a medical or surgical diagnosis or treatment of an illness or injury, or in connection with maternity or well-baby care.

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on the same basis as the related maternity care for a period not to exceed 42 days following termination of the pregnancy and thereafter cost-shared on the basis of the inpatient or outpatient status of the beneficiary when medically necessary services and supplies are received.

17. Biofeedback Therapy. Biofeedback therapy is a technique by which a person is taught to exercise control over a physiologic process occurring within the body. By using modern biomedical instruments the patient learns how a specific physiologic system within his body operates and how to modify the performance of this particular system.

a. Benefits provided. CHAMPUS benefits are payable for services and supplies in connection with electrothermal, electromyograph and electrodermal biofeedback therapy when there is documentation that the patient has undergone an appropriate medical evaluation, that their present condition is not responding to or no longer responds to other forms of conventional treatment, and only when provided as treatment for the following conditions:

(1) Adjunctive treatment for Raynaud's Syndrome.

(2) Adjunctive treatment for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, or incapacitating muscle spasm or weakness.

b. Limitations. Payable benefits include initial intake evaluation. Treatment following the initial intake evaluation is limited to a maximum of 20 inpatient and outpatient biofeedback treatments per calendar year.

c. Exclusions. Benefits are excluded for biofeedback therapy for the treatment of ordinary muscle tension states or for psychosomatic conditions. Benefits are also excluded for the rental or purchase of biofeedback equipment.

d. Provider requirements. A provider of biofeedback therapy must be a CHAMPUS-authorized provider. (Refer to CHAPTER 6, "Authorized Providers.") If biofeedback treatment is provided by other than a physician, the patient must be referred by a physician.

e. Implementation Guidelines. The Director, OCHAMPUS, shall issue guidelines as are necessary to implement the provisions of this paragraph.

18. Cardiac Rehabilitation. Cardiac rehabilitation is the process by which individuals are restored to their optimal physical, medical and psychological status, after a cardiac event. Cardiac rehabilitation is often divided into three phases. Phase I begins during inpatient hospitalization and is managed by the patient's personal physician. Phase II is a medically supervised outpatient program which begins following discharge. Phase III is a lifetime maintenance program emphasizing continuation of physical fitness with periodic followup. Each phase includes an exercise component, patient education, and risk factor modification. There may be considerable variation in program components, intensity and duration.

a. Benefits Provided. CHAMPUS benefits are available on an inpatient or outpatient basis for services and supplies provided in connection with a cardiac rehabilitation program when ordered by a physician and provided as treatment for patients who have experienced the following cardiac events within the preceding twelve (12) months:

- (1) Myocardial Infarction.
- (2) Coronary Artery Bypass Graft.
- (3) Coronary Angioplasty.
- (4) Percutaneous Transluminal Coronary Angioplasty.
- (5) Chronic Stable Angina (see limitations below).

b. Limitations. Payable benefits include separate allowance for the initial evaluation and testing. Outpatient treatment following the initial intake evaluation and testing is limited to a maximum of thirty-six (36) sessions per cardiac event, usually provided 3 sessions per week for twelve weeks. Patient's diagnosed with chronic stable angina are limited to one treatment episode (36 sessions) in a calendar year.

c. Exclusions. Phase III cardiac rehabilitation lifetime maintenance programs performed at home or in medically unsupervised settings are not covered.

d. Providers. A provider of cardiac rehabilitation services must be a CHAMPUS authorized hospital. (Refer to Chapter 6, "Authorized Providers.") All cardiac rehabilitation services must be ordered by a physician.

e. Payment. Payment for outpatient treatment will be based on an all inclusive allowable charge per session. Inpatient treatment will be paid based upon the reimbursement system in place for the hospital where the services are rendered.

f. Implementation Guidelines: The Director of OCHAMPUS shall issue guidelines as are necessary to implement the provisions of this paragraph.

19. Hospice care. Hospice care is a program which provides an integrated set of services and supplies designed to care for the terminally ill. This type of care emphasizes palliative care and supportive services, such as pain control and home care, rather than cure-oriented services provided in institutions that are otherwise the primary focus under CHAMPUS. The benefit provides coverage for a humane and sensible approach to care during the last days of life for some terminally ill patients.

a. Benefit coverage. CHAMPUS beneficiaries who are terminally ill (that is, a life expectancy of six months or less if the disease runs its normal course) will be eligible for the following services and supplies in lieu of most other CHAMPUS benefits:

(1) Physician services.

(2) Nursing care provided by or under the supervision of a registered professional nurse.

(3) Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician. Medical social services include, but are not limited to the following:

(a) Assessment of social and emotional factors related to the beneficiary's illness, need for care, response to treatment, and adjustment to care.

(b) Assessment of the relationship of the beneficiary's medical and nursing requirements to the individual's home situation, financial resources, and availability of community resources.

(c) Appropriate action to obtain available community resources to assist in resolving the beneficiary's problem.

(d) Counseling services that are required by the beneficiary.

(4) Counseling services provided to the terminally ill individual and the family member or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care-giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. Bereavement counseling, which consists of counseling services provided to the individual's family after the individual's death, is a required hospice service but it is not reimbursable.

(5) Home health aide services furnished by qualified aides and homemaker services. Home health aides may provide personal care services. Aides also may perform household services to maintain a safe and sanitary environment in areas of the home used by the patient. Examples of such services are changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the individual to carry out the plan of care. Qualifications for home health aides can be found in 42 C.F.R. section 484.36.

(6) Medical appliances and supplies, including drugs and biologicals. Only drugs that are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment, as well as other self-help and personal comfort items related to the palliation or management of the patient's condition while he or she is under hospice care. Equipment is provided by the hospice for use in the beneficiary's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care. Medical appliances and supplies are included within the hospice all-inclusive rates.

(7) Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

(8) Short-term inpatient care provided in a Medicare participating hospice inpatient unit, or a Medicare participating hospital, skilled nursing facility (SNF) or, in the case of respite care, a Medicaid-certified nursing facility that additionally meets the special hospice standards regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. Inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home. Respite care is the only type of inpatient care that may be provided in a Medicaid-certified nursing facility. The limitations on custodial care and personal comfort items applicable to other CHAMPUS services are not applicable to hospice care.

b. Core services. The hospice must ensure that substantially all core services are routinely provided directly by hospice employees; i.e., physician services, nursing care, medical social services, and counseling for individuals and care givers. Refer to paragraphs E.19.a.(1), E.19.a.(2), E.19.a.(3), and E.19.a.(4) of this chapter.

c. Non-core services. While non-core services (i.e., home health aide services, medical appliances and supplies, drugs and biologicals, physical therapy, occupational therapy, speech-language pathology and short-term inpatient care) may be provided under arrangements with other agencies or organizations, the hospice must maintain professional management of the patient at all times and in all settings. Refer to paragraphs E.19.a.(5), E.19.a.(6), E.19.a.(7), and E.19.a.(8) of this chapter.

d. Availability of services. The hospice must make nursing services, physician services, and drugs and biologicals routinely available on a 24-hour basis. All other covered services must be made available on a

24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of the terminal illness and related condition. These services must be provided in a manner consistent with accepted standards of practice.

e. Periods of care. Hospice care is divided into distinct periods/episodes of care. The terminally ill beneficiary may elect to receive hospice benefits for an initial period of 90 days, a subsequent period of 90 days, a second subsequent period of 30 days, and a final period of unlimited duration.

f. Conditions for coverage. The CHAMPUS beneficiary must meet the following conditions/criteria in order to be eligible for the hospice benefits and services referenced in paragraph E.19.a. of this chapter.

(1) There must be written certification in the medical record that the CHAMPUS beneficiary is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

(a) Timing of certification. The hospice must obtain written certification of terminal illness for each of the election periods described in paragraph E.19.f.(2) of this chapter, even if a single election continues in effect for two, three or four periods.

1 Basic requirement. Except as provided in paragraph E.19.f.(1)(a)2 of this chapter, the hospice must obtain the written certification no later than two calendar days after the period begins.

2 Exception. For the initial 90-day period, if the hospice cannot obtain the written certifications within two calendar days, it must obtain oral certifications within two calendar days, and written certifications no later than eight calendar days after the period begins.

(b) Sources of certification. Physician certification is required for both initial and subsequent election periods.

1 For the initial 90-day period, the hospice must obtain written certification statements (and oral certification statements if required under paragraph E.19.f.(1)(a)2 of this chapter) from:

a The individual's attending physician if the individual has an attending physician; and

b The medical director of the hospice or the physician member of the hospice interdisciplinary group.

2 For subsequent periods, the only requirement is certification by one of the physicians listed in paragraph E.19.f.(1)(b)1 b of this section.

(2) The terminally ill beneficiary must elect to receive hospice care for each specified period of time; i.e., the two 90-day periods, a subsequent 30-day period, and a final period of unlimited duration. If the individual is found to be mentally incompetent, his or her representative may file the election statement. Representative means an individual who has been authorized under State law to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is found to be mentally incompetent.

(a) The episodes of care must be used consecutively; i.e., the two 90-day periods first, then the 30-day period, followed by the final period. The periods of care may be elected separately at different times.

(b) The initial election will continue through subsequent election periods without a break in care as long as the individual remains in the care of the hospice and does not revoke the election.

(c) The effective date of the election may begin on the first day of hospice care or any subsequent day of care, but the effective date cannot be made prior to the date that the election was made.

(d) The beneficiary or representative may revoke a hospice election at any time, but in doing so, the remaining days of that particular election period are forfeited and standard CHAMPUS coverage resumes. To revoke the hospice benefit, the beneficiary or representative must file a signed statement of revocation with the hospice. The statement must provide the date that the revocation is to be effective. An individual or representative may not designate an effective date earlier than the date that the revocation is made.

(e) If an election of hospice benefits has been revoked, the individual, or his or her representative may at any time file a hospice election for any period of time still available to the individual, in accordance with Chapter 4.E.19.f.(2).

(f) A CHAMPUS beneficiary may change, once in each election period, the designation of the particular hospice from which he or she elects to receive hospice care. To change the designation of hospice programs the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following information:

1 The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care.

2 The date the change is to be effective.

(g) Each hospice will design and print its own election statement to include the following information:

1 Identification of the particular hospice that will provide care to the individual.

2 The individual's or representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness.

3 The individual's or representative's acknowledgment that he or she understands that certain other CHAMPUS services are waived by the election.

4 The effective date of the election.

5 The signature of the individual or representative, and the date signed.

(h) The hospice must notify the CHAMPUS contractor of the initiation, change or revocation of any election.

(3) The beneficiary must waive all rights to other CHAMPUS payments for the duration of the election period for:

(a) Care provided by any hospice program other than the elected hospice unless provided under arrangements made by the elected hospice; and

(b) Other CHAMPUS basic program services/benefits related to the treatment of the terminal illness for which hospice care was elected, or to a related condition, or that are equivalent to hospice care, except for services provided by:

1 the designated hospice;

2 another hospice under arrangements made by the designated hospice; or

3 an attending physician who is not employed by or under contract with the hospice program.

(c) Basic CHAMPUS coverage will be reinstated upon revocation of the hospice election.

(4) A written plan of care must be established by a member of the basic interdisciplinary group assessing the patient's needs. This group must have at least one physician, one registered professional nurse, one social worker, and one pastoral or other counselor.

(a) In establishing the initial plan of care the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member before writing the initial plan of care.

(b) At least one of the persons involved in developing the initial plan must be a nurse or physician.

(c) The plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care.

(d) The other two members of the basic interdisciplinary group -- the attending physician and the medical director or physician designee -- must review the initial plan of care and provide their input to the process of establishing the plan of care within two calendar days following the day of assessment. A meeting of group members is not required within this 2-day period. Input may be provided by telephone.

(e) Hospice services must be consistent with the plan of care for coverage to be extended.

(f) The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, medical director or physician designee and interdisciplinary group. These reviews must be documented in the medical records.

(g) The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

(h) The plan must include an assessment of the individual's needs and identification of the services, including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

(5) Complete medical records and all supporting documentation must be submitted to the CHAMPUS contractor within 30 days of the date of its request. If records are not received within the designated time frame, authorization of the hospice benefit will be denied and any prior payments made will be recouped. A denial issued for this reason is not an initial determination under Chapter 10, and is not appealable.

g. Appeal rights under hospice benefit. A beneficiary or provider is entitled to appeal rights for cases involving a denial of benefits in accordance with the provisions of this Chapter and Chapter 10.

F. BENEFICIARY OR SPONSOR LIABILITY

1. General. As stated in the introductory paragraph to this chapter, the Basic Program is essentially a supplemental program to the Uniformed

Services direct medical care system. To encourage use of the Uniformed Services direct medical care system wherever its facilities are available and appropriate, the Basic Program benefits are designed so that it is to the financial advantage of a CHAMPUS beneficiary or sponsor to use the direct medical care system. When medical care is received from civilian sources, a CHAMPUS beneficiary is responsible for payment of certain deductible and cost-sharing amounts in connection with otherwise covered services and supplies. By statute, this joint financial responsibility between the beneficiary or sponsor and CHAMPUS is more favorable for dependents of active duty members than for other classes of beneficiaries.

2. Dependents of active duty members of the Uniformed Services.
CHAMPUS beneficiary or sponsor liability set forth for dependents of active duty members is as follows:

a. Annual fiscal year deductible for outpatient services and supplies.

(1) For care rendered all eligible beneficiaries prior to April 1, 1991, or when the active duty sponsor's pay grade is E-4 or below, regardless of the date of care:

(a) Individual Deductible: Each beneficiary is liable for the first fifty dollars (\$50.00) of the CHAMPUS-determined allowable amount on claims for care provided in the same fiscal year.

(b) Family Deductible: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed one hundred dollars (\$100.00).

(2) For care rendered on or after April 1, 1991, for all CHAMPUS beneficiaries except dependents of active duty sponsors of pay grades E-4 or below:

(a) Individual Deductible: Each beneficiary is liable for the first one hundred and fifty dollars (\$150.00) of the CHAMPUS-determined allowable amount on claims for care provided in the same fiscal year.

(b) Family Deductible: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed three hundred dollars (\$300.00).

(3) CHAMPUS-Approved Ambulatory Surgical Centers or Birthing Centers. No deductible shall be applied to allowable amounts for services or items rendered to active duty or authorized NATO dependents.

(4) Allowable Amount does not exceed Deductible Amount. If fiscal year allowable amounts for two or more beneficiary members of a family total less than \$100.00 (\$300.00 if 2.a.(2)(b) above applies), but

none of the beneficiary members submit a claim for over \$50.00 (\$150.00 if 2.a.(2)(a) above applies), neither the family nor the individual deductible will have been met and no CHAMPUS benefits are payable.

(5) For any family the outpatient deductible amounts will be applied sequentially as the CHAMPUS claims are processed.

(6) If the fiscal year outpatient deductible under either F.2.a.(1) or F.2.a.(2) above has been met by a beneficiary or a family through the submission of a claim or claims to a CHAMPUS fiscal intermediary in another geographic location from the location where a current claim is being submitted, the beneficiary or sponsor must obtain a deductible certificate from the CHAMPUS fiscal intermediary where the applicable beneficiary or family fiscal year deductible was met. Such deductible certificate must be attached to the current claim being submitted for benefits. Failure to obtain a deductible certificate under such circumstances will result in a second beneficiary or family fiscal year deductible being applied. However, this second deductible may be reimbursed once appropriate documentation, as described in this subparagraph F.2.a.(6), is supplied to the CHAMPUS fiscal intermediary applying the second deductible (refer to section A. of Chapter 7 of this Regulation).

(7) Notwithstanding the dates specified in paragraphs F.2.a.(1) and (2), in the case of the dependents of active duty members of rank E-5 or above with Persian Gulf conflict service, the deductible shall be the amount specified in paragraph (1) for care rendered prior to October 1, 1991, and the amount specific in paragraph (2) for care rendered after October 1, 1991. For purposes of the preceding sentence, a member with Persian Gulf conflict service is a member who is, or was entitled to special pay for hostile fire/imminent danger authorized by 37 U.S.C. 310, for services in the Persian Gulf area in connection with Operation Desert Shield or Operation Desert Storm.

b. Inpatient cost-sharing. Dependents of active duty members of the Uniformed Services or their sponsors are responsible for the payment of the first \$25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider (refer to Chapter 6 of this Regulation), or the amount the beneficiary or sponsor would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater.

NOTE: The Secretary of Defense (after consulting with the Secretary of Health and Human Services and the Secretary of Transportation) prescribes the fair charges for inpatient hospital care provided through Uniformed Services medical facilities. This determination is made each fiscal year.

(1) Inpatient cost-sharing payable with each separate inpatient admission. A separate cost-sharing amount (as described in this subsection F.2.) is payable for each inpatient admission to a hospital or other authorized institution, regardless of the purpose of the admission (such as medical or surgical), regardless of the number of times the beneficiary is admitted, and regardless of whether or not the inpatient admissions are for the same or related conditions; except that successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the inpatient cost-share payable, provided not more than 60 days have elapsed between the successive admissions. However, notwithstanding this provision, all admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions (refer to section B. of this chapter).

(2) Multiple family inpatient admissions. A separate cost-sharing amount is payable for each inpatient admission, regardless of whether or not two or more beneficiary members of a family are admitted at the same time or from the same cause (such as an accident). A separate beneficiary inpatient cost-sharing amount must be applied for each separate admission on each beneficiary member of the family.

(3) Newborn patient in his or her own right. When a newborn infant remains as an inpatient in his or her own right (usually after the mother is discharged), the newborn child becomes the beneficiary and patient and the extended inpatient stay becomes a separate inpatient admission. In such a situation, a new, separate inpatient cost-sharing amount is applied. If a multiple birth is involved (such as twins or triplets) and two or more newborn infants become patients in their own right, a separate inpatient cost-sharing amount must be applied to the inpatient stay for each newborn child who has remained as an inpatient in his or her own right.

c. Outpatient cost-sharing. Dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of 20 percent of the CHAMPUS-determined allowable cost or charge beyond the annual fiscal year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

d. Ambulatory surgery. Notwithstanding the above provisions pertaining to outpatient cost-sharing, dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of \$25 for surgical care that is authorized and received while in an outpatient status and that has been designated in guidelines issued by the Director, OCHAMPUS, or a designee.

e. Psychiatric partial hospitalization services. Institutional and professional services provided under the psychiatric partial hospitalization program authorized by paragraph B.10. of this chapter shall be cost-shared as inpatient services.

3. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees. CHAMPUS beneficiary liability set forth for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. The annual fiscal year deductible for otherwise covered outpatient services or supplies provided retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees, is the same as the annual fiscal year outpatient deductible applicable to dependents of active duty members of rank E-5 or above (refer to paragraph F.2.a.(1) or (2) of this chapter).

b. Inpatient cost-sharing. Cost-sharing amounts for inpatient services shall be as follows:

(1) Services subject to the CHAMPUS DRG-based payment system. The cost-share shall be the lesser of an amount calculated by multiplying a per diem amount for each day of the hospital stay except the day of discharge or 25 percent of the hospital's billed charges. The per diem amount shall be calculated so that total cost-sharing amounts for these beneficiaries is equivalent to 25 percent of the CHAMPUS-determined allowable costs for covered services or supplies provided on an inpatient basis by authorized providers. The per diem amount shall be published annually by CHAMPUS.

(2) Services subject to the mental health per diem payment system. The cost-share is dependent upon whether the hospital is paid a hospital-specific per diem or a regional per diem under the provisions of subsection A.2. of Chapter 14. With respect to care paid for on the basis of a hospital-specific per diem, the cost-share shall be 25% of the hospital-specific per diem amount. For care paid for on the basis of a regional per diem, the cost share shall be the lower of a fixed daily amount or 25% of the hospital's billed charges. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25% of total payments under the mental health per diem payment system. This fixed daily amount shall be updated annually and published in the Federal Register along with the per diems published pursuant to subparagraph A.2.d.(2) of Chapter 14.

(3) Other services. For services exempt from the CHAMPUS DRG-based payment system and the CHAMPUS mental health per diem payment system and services provided by institutions other than hospitals, the cost-share shall be 25% of the CHAMPUS-determined allowable charges.

c. Outpatient cost-sharing.

(1) For services other than ambulatory surgery services. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees are responsible for payment of 25 percent of the CHAMPUS-determined allowable costs or charges beyond the annual fiscal

year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

(2) For services subject to the ambulatory surgery payment method. For services subject to the ambulatory surgery payment method set forth in Chapter 14 D., of this regulation, the cost share shall be the lesser of: 25 percent of the payment amount provided pursuant to Chapter 14.D.; or 25 percent of the center's billed charges.

d. Psychiatric partial hospitalization services. Institutional and professional services provided under the psychiatric partial hospitalization program authorized by paragraph B.10. of this chapter shall be cost-shared as inpatient services.

4. Former spouses. CHAMPUS beneficiary liability set forth for former spouses eligible under the provisions of paragraph B.2.b. of Chapter 3 is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. An eligible former spouse is responsible for the payment of the first \$150 of the CHAMPUS-determined reasonable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year. (Except for services received prior to April 1, 1991, the deductible amount is \$50.00). The former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of any CHAMPUS-eligible children.

b. Inpatient cost-sharing. Eligible former spouses are responsible for the payment of cost-sharing amounts the same as those required for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.

c. Outpatient cost-sharing. Eligible former spouses are responsible for payment of 25 percent of the CHAMPUS-determined reasonable costs or charges beyond the annual fiscal year deductible amount for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

5. Cost-Sharing under the Military-Civilian Health Services Partnership Program. Cost-sharing is dependent upon the type of partnership program entered into, whether external or internal. (See section P. of Chapter 1, for general requirements of the Military-Civilian Health Services Partnership Program.)

a. External Partnership Agreement. Authorized costs associated with the use of the civilian facility will be financed through CHAMPUS under the normal cost-sharing and reimbursement procedures applicable under CHAMPUS.

b. Internal Partnership Agreement. Beneficiary cost-share under internal agreements will be the same as charges prescribed for care in military treatment facilities.

6. Amounts over CHAMPUS-determined allowable costs or charges. It is the responsibility of the CHAMPUS fiscal intermediary to determine allowable costs for services and supplies provided by hospitals and other institutions and allowable charges for services and supplies provided by physicians, other individual professional providers, and other providers. Such CHAMPUS-determined allowable costs or charges are made in accordance with the provisions of Chapter 14. All CHAMPUS benefits, including calculation of the CHAMPUS or beneficiary cost-sharing amounts, are based on such CHAMPUS-determined allowable costs or charges. The effect on the beneficiary when the billed cost or charge is over the CHAMPUS-determined allowable amount is dependent upon whether or not the applicable claim was submitted on a participating basis on behalf of the beneficiary or submitted directly by the beneficiary on a nonparticipating basis and on whether the claim is for inpatient hospital services subject to the CHAMPUS DRG-based payment system. This provision applies to all classes of CHAMPUS beneficiaries.

NOTE: When the provider "forgives" or "waives" any beneficiary liability, such as amounts applicable to the annual fiscal year deductible for outpatient services or supplies, or the inpatient or outpatient cost-sharing as previously set forth in this section, the CHAMPUS-determined allowable charge or cost allowance (whether payable to the CHAMPUS beneficiary or sponsor, or to a participating provider) shall be reduced by the same amount.

a. Participating providers. There are several circumstances under which institutional and individual providers may be Participating Providers, either on a mandatory basis or a voluntary basis. See Chapter 6, A.8. A Participating Provider, whether participating for all claims or on a claim-by-claim basis, must accept the CHAMPUS-determined allowable amount as payment in full for the medical services or supplies provided, and must accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing and deductible amounts paid by or on behalf of the beneficiary as payment in full for the covered medical services or supplies. Therefore, when costs or charges are submitted on a participating basis, the patient is not obligated to pay any amounts disallowed as being over the CHAMPUS-determined allowable cost or charge for authorized services or supplies.

b. Nonparticipating providers. Nonparticipating providers are those providers who do not agree on the CHAMPUS claim form to participate and thereby do not agree to accept the CHAMPUS-determined allowable costs or charges as the full charge. For otherwise covered services and supplies provided by such nonparticipating CHAMPUS providers, payment is made directly to the beneficiary or sponsor and the beneficiary is liable under applicable law for any amounts over the CHAMPUS-determined allowable costs or charges. CHAMPUS shall have no responsibility for any amounts over allowable costs or charges as determined by CHAMPUS.

7. [Reserved]

8. Cost-sharing for services provided under special discount arrangements.

a. General rule. With respect to services determined by the Director, OCHAMPUS (or designee) to be covered by Chapter 14, section I., the Director, OCHAMPUS (or designee) has authority to establish, as an exception to the cost-sharing amount normally required pursuant to this chapter, a different cost-share amount that appropriately reflects the application of the statutory cost-share to the discount arrangement.

b. Specific applications. The following are examples of applications of the general rule; they are not all inclusive.

(1) In the case of services provided by individual health care professionals and other noninstitutional providers, the cost-share shall be the usual percentage of the CHAMPUS allowable charge determined under Chapter 14, section I.

(2) In the case of services provided by institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under Chapter 14, section A.1. or per-diem amount under Chapter 14, section A.2.), if the discount rate is lower than the pre-set rate, the cost-share amount that would apply for a beneficiary other than an active duty dependent pursuant to the normal pre-set rate would be reduced by the same percentage by which the pre-set rate was reduced in setting the discount rate.

9. Waiver of deductible amounts or cost-sharing not allowed.

a. General rule. Because deductible amounts and cost sharing are statutorily mandated, except when specifically authorized by law (as determined by the Director, OCHAMPUS), a provider may not waive or forgive beneficiary liability for annual deductible amounts or inpatient or outpatient cost-sharing, as set forth in this chapter.

b. Exception for bad debts. This general rule is not violated in cases in which a provider has made all reasonable attempts to effect collection, without success, and determines in accordance with generally accepted fiscal management standards that the beneficiary liability in a particular case is an uncollectible bad debt.

c. Remedies for noncompliance. Potential remedies for noncompliance with this requirement include:

(1) A claim for services regarding which the provider has waived the beneficiary's liability may be disallowed in full, or, alternatively, the amount payable for such a claim may be reduced by the amount of the beneficiary liability waived.

(2) Repeated noncompliance with this requirement is a basis for exclusion of a provider.

G. EXCLUSIONS AND LIMITATIONS

In addition to any definitions, requirements, conditions, or limitations enumerated and described in other chapters of this Regulation, the following specifically are excluded from the Basic Program:

1. Not medically or psychologically necessary. Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or injury, for the diagnosis and treatment of pregnancy, or for well-baby care except as provided in the following paragraph.

2. Unnecessary diagnostic tests. X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms except for cancer screening mammography and cancer screening papanicolaou (PAP) smears provided under the terms and conditions contained in the guidelines adopted by the Director, OCHAMPUS.

3. Institutional level of care. Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.

4. Diagnostic admission. Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.

NOTE: If it is determined that the diagnostic x-ray, laboratory, and pathological services and machine tests performed during such admission were medically necessary and would have been covered if performed on an outpatient basis, CHAMPUS benefits may be extended for such diagnostic procedures only, but cost-sharing will be computed as if performed on an outpatient basis.

5. Unnecessary postpartum inpatient stay, mother or newborn. Postpartum inpatient stay of a mother for purposes of staying with the newborn infant (usually primarily for the purpose of breast feeding the infant) when the infant (but not the mother) requires the extended stay; or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.

6. Therapeutic absences. Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by the Director, OCHAMPUS, or a designee. For cost-sharing provisions refer to Chapter 14, paragraph F.3.

7. Custodial care. Custodial care regardless of where rendered, except as otherwise specifically provided in paragraphs E.12.b., E.12.c. and E.12.d. of this chapter.

8. Domiciliary care. Inpatient stays primarily for domiciliary care purposes.

9. Rest or rest cures. Inpatient stays primarily for rest or rest cures.

10. Amounts above allowable costs or charges. Costs of services and supplies to the extent amounts billed are over the CHAMPUS determined allowable cost or charge, as provided for in Chapter 14.

11. No legal obligation to pay, no charge would be made. Services or supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary or sponsor was not eligible under CHAMPUS; or whenever CHAMPUS is a secondary payer for claims subject to the CHAMPUS DRG-based payment system, amounts, when combined with the primary payment, which would be in excess of charges (or the amount the provider is obligated to accept as payment in full, if it is less than the charges).

12. Furnished without charge. Services or supplies furnished without charge.

13. Furnished by local, state, or Federal Government. Services and supplies paid for, or eligible for payment, directly or indirectly by a local, state, or Federal Government, except as provided under CHAMPUS, or by government hospitals serving the general public, or medical care provided by a Uniformed Service medical care facility, or benefits provided under title XIX of the Social Security Act (Medicaid) (reference (h)) (refer to Chapter 8 of this Regulation).

14. Study, grant, or research programs. Services and supplies provided as a part of or under a scientific or medical study, grant, or research program.

15. Not in accordance with accepted standards, experimental or investigational. Services and supplies not provided in accordance with accepted professional medical standards; or related to essentially experimental or investigational procedures or treatment regimens.

16. Immediate family, household. Services or supplies provided or prescribed by a member of the beneficiary's immediate family, or a person living in the beneficiary's or sponsor's household.

17. Double coverage. Services and supplies that are (or are eligible to be) payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare (refer to Chapter 8 of this Regulation).

18. Nonavailability Statement required. Services and supplies provided under circumstances or in geographic locations requiring a Nonavailability Statement (DD Form 1251), when such a statement was not obtained.

19. Preauthorization required. Services or supplies which require preauthorization if preauthorization was not obtained. Services and supplies which were not provided according to the terms of the preauthorization. The Director, OCHAMPUS, or a designee, may grant an exception to the requirement for preauthorization if the services otherwise would be payable except for the failure to obtain preauthorization.

20. Psychoanalysis or psychotherapy, part of education. Psychoanalysis or psychotherapy provided to a beneficiary or any member of the immediate family that is credited towards earning a degree or furtherance of the education or training of a beneficiary or sponsor, regardless of diagnosis or symptoms that may be present.

21. Runaways. Inpatient stays primarily to control or detain a runaway child, whether or not admission is to an authorized institution.

22. Services or supplies ordered by a court or other government agency. Services or supplies, including inpatient stays, directed or agreed to by a court or other governmental agency. However, those services and supplies (including inpatient stays) that otherwise are medically or psychologically necessary for the diagnosis or treatment of a covered condition and that otherwise meet all CHAMPUS requirements for coverage are not excluded.

23. Work-related (occupational) disease or injury. Services and supplies required as a result of occupational disease or injury for which any benefits are payable under a worker's compensation or similar law, whether or not such benefits have been applied for or paid; except if benefits provided under such laws are exhausted.

24. Cosmetic, reconstructive, or plastic surgery. Services and supplies in connection with cosmetic, reconstructive, or plastic surgery except as specifically provided in subsection E.8. of this chapter.

25. Surgery, psychological reasons. Surgery performed primarily for psychological reasons (such as psychogenic).

26. Electrolysis.

27. Dental care. Dental care or oral surgery, except as specifically provided in subsection E.10. of this chapter.

28. Obesity, weight reduction. Services and supplies related to obesity or weight reduction whether surgical or nonsurgical; wiring of the jaw or any procedure of similar purpose, regardless of the circumstances under which performed; except that benefits may be provided for the gastric bypass, gastric stapling, or gastroplasty procedures in connection with morbid obesity as provided in subsection E.15. of this chapter.

29. Transsexualism or such other conditions as gender dysphoria. Services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in subsection E.7. of this chapter.

30. Therapy or counseling for sexual dysfunctions or sexual inadequacies. Sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy for mental disorders involving sex deviations (e.g., transvestic fetishism), or other similar services, and any supplies provided in connection with therapy for sexual dysfunctions or inadequacies.

31. Corns, calluses, and toenails. Removal of corns or calluses or trimming of toenails and other routine podiatry services, except those required as a result of a diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

32. Dyslexia.

33. Surgical sterilization, reversal. Surgery to reverse surgical sterilization procedures.

34. Noncoital reproductive procedures including artificial insemination, in-vitro fertilization, gamete intrafallopian transfer and all other such reproductive technologies. Services and supplies related to artificial insemination (including semen donors and semen banks), in-vitro fertilization, gamete intrafallopian transfer and all other noncoital reproductive technologies.

35. Nonprescription contraceptives.

36. Tests to determine paternity or sex of a child. Diagnostic tests to establish paternity of a child; or tests to determine sex of an unborn child.

37. Preventive care. Preventive care, such as routine, annual, or employment requested physical examinations; routine screening procedures; immunizations; except that the following are not excluded:

- a. Well-baby care, including newborn examination, Phenylketonuria (PKU) testing and newborn circumcision.
- b. Rabies shots.
- c. Tetanus shot following an accidental injury.
- d. Rh immune globulin.
- e. Genetic tests as specified in paragraph E.3.b. of this chapter.

f. Immunizations and physical examinations provided when required in the case of dependents of active duty military personnel who are traveling outside the United States as a result of an active member's duty assignment and such travel is being performed under orders issued by a Uniformed Service.

g. Screening mammography for asymptomatic women 35 years of age and older when provided under the terms and conditions contained in the guidelines adopted by the Director OCHAMPUS.

h. Cancer screening papanicolaou (PAP) smear for women who are or have been sexually active, and women 18 years of age and older under the terms and conditions contained in the guidelines adopted by the Director, OCHAMPUS.

38. Chiropractors and naturopaths. Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider.

39. Counseling. Counseling services that are not medically necessary in the treatment of a diagnosed medical condition; for example, educational counseling, vocational counseling, nutritional counseling, counseling for socio-economic purposes, diabetic self-education programs, stress management, life style modification, etc. Services provided by a certified marriage and family therapist, pastoral or mental health counselor in the treatment of a mental disorder are covered only as specifically provided in Chapter 6. Services provided by alcoholism rehabilitation counselors and certified addiction counselors are covered only when rendered in a CHAMPUS-authorized treatment setting and only when the cost of those services is included in the facility's CHAMPUS-determined allowable cost-rate.

40. Acupuncture. Acupuncture, whether used as a therapeutic agent or as an anesthetic.

41. Hair transplants, wigs, or hairpieces

NOTE: In accordance with Section 744 of the DoD Appropriation Act for 1981 (reference (o)), CHAMPUS coverage for wigs or hairpieces is permitted effective December 15, 1980, under the conditions listed below. Continued availability of benefits will depend on the language of the annual DoD Appropriation Acts.

a. Benefits provided. Benefits may be extended, in accordance with the CHAMPUS-determined allowable charge, for one wig or hairpiece per beneficiary (lifetime maximum) when the attending physician certifies that alopecia has resulted from treatment of a malignant disease and the beneficiary certifies that a wig or hairpiece has not been obtained previously through the U.S. Government (including the Veterans Administration).

b. Exclusions. The wig or hairpiece benefit does not include coverage for the following:

(1) Alopecia resulting from conditions other than treatment of malignant disease.

(2) Maintenance, wig or hairpiece supplies, or replacement of the wig or hairpiece.

(3) Hair transplants or any other surgical procedure involving the attachment of hair or a wig or hairpiece to the scalp.

(4) Any diagnostic or therapeutic method or supply intended to encourage hair regrowth.

42. Education or training. Self-help, academic education or vocational training services and supplies, unless the provisions of Chapter 4, paragraph B.1.e., relating to general or special education, apply.

43. Exercise/Relaxation/Comfort Devices. Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

44. Exercise. General exercise programs, even if recommended by a physician and regardless of whether or not rendered by an authorized provider. In addition, passive exercises and range of motion exercises also are excluded, except when prescribed by a physician and rendered by a physical therapist concurrent to, and as an integral part of, a comprehensive program of physical therapy.

45. Audiologist, speech therapist. Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of treatment addressed to the physical defect itself and not to any educational or occupational deficit.

46. Vision care. Eye exercises or visual training (orthoptics).

47. Eye and hearing examinations. Eye and hearing examinations except as specifically provided in paragraph C.2.p. of this chapter or except when rendered in connection with medical or surgical treatment of a covered illness or injury. Vision and hearing screening in connection with well-baby care is not excluded.

48. Prosthetic devices. Prostheses, except artificial limbs and eyes, or if an item is inserted surgically in the body as an integral part of a surgical procedure. All dental prostheses are excluded, except for those specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

49. Orthopedic shoes. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes, or regular shoes later built up.

50. Eyeglasses. Eyeglasses, spectacles, contact lenses, or other optical devices, except as specifically provided under subsection E.6. of this chapter.

51. Hearing aids. Hearing aids or other auditory sensory enhancing devices.

52. Telephonic services. Services or advice rendered by telephone or other telephonic device, including remote monitoring, except for transtelephonic monitoring of cardiac pacemakers.

53. Air conditioners, humidifiers, dehumidifiers, and purifiers.

54. Elevators or chair lifts.

55. Alterations. Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.

56. Clothing. Items of clothing or shoes, even if required by virtue of an allergy (such as cotton fabric as against synthetic fabric and vegetable dyed shoes).

57. Food, food substitutes. Food, food substitutes, vitamins, or other nutritional supplements, including those related to prenatal care.

58. Enuresis. Enuretic devices; enuretic conditioning programs.

59. RESERVED.

60. Autopsy and postmortem.

61. Camping. All camping even though organized for a specific therapeutic purpose (such as diabetic camp or a camp for emotionally disturbed children), and even though offered as a part of an otherwise covered treatment plan or offered through a CHAMPUS-approved facility.

62. Housekeeper, companion. Housekeeping, homemaker, or attendant services; sitter or companion.

63. Noncovered condition, unauthorized provider. All services and supplies (including inpatient institutional costs) related to a noncovered condition or treatment, or provided by an unauthorized provider.

64. Comfort or convenience. Personal, comfort, or convenience items such as beauty and barber services, radio, television, and telephone.

65. "Stop smoking" programs. Services and supplies related to "stop smoking" regimens.

66. Megavitamin psychiatric therapy, orthomolecular psychiatric therapy.

67. Transportation. All transportation except by ambulance, as specifically provided under section D. of this chapter, and except as authorized in subsection E.5. of this chapter.

68. Travel. All travel even though prescribed by a physician and even if its purpose is to obtain medical care, except as specified in subsection A.6. of this chapter in connection with a CHAMPUS-required physical examination.

69. Institutions. Services and supplies provided by other than a hospital, unless the institution has been approved specifically by OCHAMPUS. Nursing homes, intermediate care facilities, halfway houses, homes for the aged, or institutions of similar purpose are excluded from consideration as approved facilities under the Basic Program.

NOTE: In order to be approved under CHAMPUS, an institution must, in addition to meeting CHAMPUS standards, provide a level of care for which CHAMPUS benefits are payable.

70. Supplemental diagnostic services. Diagnostic services including clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results performed by civilian providers at the request of the attending Uniformed Service medical department physician (active duty or civil service).

71. Supplemental consultations. Consultations provided by civilian providers at the request of the attending Uniformed Services medical department physician (active duty or civil service).

72. Inpatient mental health services. Effective for care received on or after October 1, 1991, services in excess of 30 days in any fiscal year (or in an admission), in the case of a patient nineteen years of age or older, 45 days in any fiscal year (or in an admission) in the case of a patient under 19 years of age, or 150 days in any fiscal year (or in an admission) in the case of inpatient mental health services provided as residential treatment care, unless coverage for such services is granted by a waiver by the Director, OCHAMPUS, or a designee. In cases involving the day limitations, waivers shall be handled in accordance with paragraphs B.8. or B.9. of this chapter. For services prior to October 1, 1991, services in excess of 60 days in any calendar year unless additional coverage is granted by the Director, OCHAMPUS, or a designee.

73. Economic interest in connection with mental health admissions. Inpatient mental health services (including both acute care and RTC services) are excluded for care received when a patient is referred to a provider of such services by a physician (or other health care professional with authority to admit) who has an economic interest in the facility to which the patient is referred, unless a waiver is granted. Requests for waiver shall be considered under the same procedure and based on the same criteria as used for obtaining preadmission authorization (or continued stay authorization for

emergency admissions), with the only additional requirement being that the economic interest be disclosed as part of the request. The same reconsideration and appeals procedures that apply to day limit waivers shall also apply to decisions regarding requested waivers of the economic interest exclusion. However, a provider may appeal a reconsidered determination that an economic relationship constitutes an economic interest within the scope of the exclusion to the same extent that a provider may appeal determinations under paragraph I.3., Chapter 15. This exclusion does not apply to services under the Program for the Handicapped (Chapter 5 of this Regulation) or provided as partial hospital care. If a situation arises where a decision is made to exclude CHAMPUS payment solely on the basis of the provider's economic interest, the normal CHAMPUS appeals process will be available.

74. Not specifically listed. Services and supplies not specifically listed as a benefit in this Regulation. This exclusion is not intended to preclude extending benefits for those services or supplies specifically determined to be covered within the intent of this Regulation by the Director, OCHAMPUS, or a designee, even though not otherwise listed.

NOTE: The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not listed specifically as an exclusion.

H. Payment and liability for certain potentially excludable services under the Peer Review Organization program.

1. Applicability. This section provides special rules that apply only to services retrospectively determined under the Peer Review Organization (PRO) program (operated pursuant to Chapter 15) to be potentially excludable (in whole or in part) from the Basic Program under section G. of this chapter. Services may be excluded by reason of being not medically necessary (subsection G.1.) at an inappropriate level (subsection G.3.) custodial care (subsection G.7.) or other reason relative to reasonableness, necessity or appropriateness (which services shall throughout the remainder of this section, be referred to as "not medically necessary"). (Also throughout the remainder of the section, "services" includes items and "provider" includes supplier.) This section does not apply to coverage determinations made by OCHAMPUS or the fiscal intermediaries which are not based on medical necessity determinations made under the PRO program.

2. Payment for certain potentially excludable expenses. Services determined under the PRO program to be potentially excludable by reason of the exclusions in section G. of this chapter for not medically necessary services will not be determined to be excludable if neither the beneficiary to whom the services were provided nor the provider (institutional or individual) who furnished the services knew, or could reasonably have been expected to know, that the services were subject to those exclusions. Payment may be made for such services as if the exclusions did not apply.

3. Liability for certain excludable services. In any case in which items or services are determined excludable by the PRO program by reason of

being not medically necessary and payment may not be made under subsection H.2., above because the requirements of subsection H.2. are not met, the beneficiary may not be held liable (and shall be entitled to a full refund from the provider of the amount excluded and any cost-share amount already paid) if:

a. The beneficiary did not know and could not reasonably have been expected to know that the services were excludable by reason of being not medically necessary; and

b. The provider knew or could reasonably have been expected to know that the items or services were excludable by reason of being not medically necessary.

4. Criteria for determining that beneficiary knew or could reasonably have been expected to have known that services were excludable. A beneficiary who receives services excludable by reason of being not medically necessary will be found to have known that the services were excludable if the beneficiary has been given written notice that the services were excludable or that similar or comparable services provided on a previous occasion were excludable and that notice was given by the OCHAMPUS, CHAMPUS PRO or fiscal intermediary, a group or committee responsible for utilization review for the provider, or the provider who provided the services.

5. Criteria for determining that provider knew or could reasonably have been expected to have known that services were excludable. An institutional or individual provider will be found to have known or been reasonably expected to have known that services were excludable under this section under any one of the following circumstances:

a. The PRO or fiscal intermediary had informed the provider that the services provided were excludable or that similar or reasonably comparable services were excludable.

b. The utilization review group or committee for an institutional provider or the beneficiary's attending physician had informed the provider that the services provided were excludable.

c. The provider had informed the beneficiary that the services were excludable.

d. The provider had received written materials, including notices, manual issuances, bulletins, guides, directives, or other materials, providing notification of PRO screening criteria specific to the condition of the beneficiary. Attending physicians who are members of the medical staff of an institutional provider will be found to have also received written materials provided to the institutional provider.

e. The services that are at issue are the subject of what are generally considered acceptable standards of practice by the local medical community.

f. Preadmission authorization was available but not requested, or concurrent review requirements were not followed.

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AUTHORIZED PROVIDERS
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(i) Professional staff. The center's professional staff is legally and professionally qualified for the performance of their professional responsibilities.

(j) Medical records. The center maintains full and complete written documentation of the services rendered to each woman admitted and each newborn delivered. A copy of the informed consent document required by subparagraph (c), above, which contains the original signature of the CHAMPUS beneficiary, signed and dated at the time of admission, must be maintained in the medical record of each CHAMPUS beneficiary admitted.

(k) Quality assurance. The center has an organized program for quality assurance which includes, but is not limited to, written procedures for regularly scheduled evaluation of each type of service provided, of each mother or newborn transferred to a hospital, and of each death within the facility.

(l) Governance and administration. The center has a governing body legally responsible for overall operation and maintenance of the center and a full-time employee who has authority and responsibility for the day-to-day operation of the center.

1. Psychiatric partial hospitalization programs. Psychiatric partial hospitalization programs must be either a distinct part of an otherwise authorized institutional provider or a freestanding program. The treatment program must be under the general direction of a psychiatrist employed by the partial hospitalization program to ensure medication and physical needs of all the patients are considered. The primary or attending provider must be a CHAMPUS authorized mental health provider, operating within the scope of his/her license. These categories include physicians, clinical psychologists, certified psychiatric nurse specialists, clinical social workers, marriage and family counselors, pastoral counselors and mental health counselors. CHAMPUS reimbursement is limited to programs complying with all requirements of Chapter 4, paragraph B.10. In addition, in order for a partial hospitalization program (PHP) to be authorized, the PHP shall comply with the following requirements:

(1) The PHP shall comply with the CHAMPUS Standards for Partial Hospitalization Programs and Facilities, as promulgated by the Director, OCHAMPUS.

(2) The PHP shall be specifically accredited by and remain in substantial compliance with standards issued by the Joint Commission on Accreditation of Healthcare Organizations under the Mental Health Manual (formerly the Consolidated Standards). NOTE: A one-time grace period is being allowed not to exceed October 1, 1994 for this provision only if the provider is already accredited under the JCAHO hospital standards. The provider must agree not to accept any new admissions for CHAMPUS patients for care beyond October 1, 1994, if accreditation and substantial compliance with the Mental Health Manual standards have not been obtained by that date.

(3) The PHP shall be licensed as a partial hospitalization program to provide PHP services within the applicable jurisdiction in which it operates.

(4) The PHP shall accept the CHAMPUS-allowable partial hospitalization program rate, as provided in Chapter 14, paragraph A.2.1., as payment in full for services provided.

(5) The PHP shall comply with all requirements of this section applicable to institutional providers generally concerning preauthorization, concurrent care review, claims processing, beneficiary liability, double coverage, utilization and quality review and other matters.

(6) The PHP must be fully operational and treating patients for a period of at least six months (with at least 30 percent minimum patient census) before an application for approval may be submitted. The PHP shall not be considered a CHAMPUS-authorized provider nor may any CHAMPUS benefits be paid to the facility for any services provided prior to the date the facility is approved by the Director, OCHAMPUS, or designee.

(7) All mental health services must be provided by a CHAMPUS-authorized mental health provider. [Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate but the individual must work under the clinical supervision of a fully qualified mental health provider employed by the PHP.] All other program services shall be provided by trained, licensed staff.

(8) The PHP shall ensure the provision of an active family therapy treatment component which assures that each patient and family participate at least weekly in family therapy provided by the institution and rendered by a CHAMPUS authorized mental health provider.

(9) The PHP must have a written agreement with at least one backup CHAMPUS-authorized hospital which specifies that the hospital will accept any and all CHAMPUS beneficiaries transferred for emergency mental health or medical/surgical care. The PHP must have a written emergency transport agreement with at least one ambulance company which specifies the estimated transport time to each backup hospital.

(10) The PHP shall enter into a participation agreement with the Director, OCHAMPUS, which shall include but which shall not be limited to the following provisions:

(a) The PHP agrees not to bill the beneficiary for services in excess of the cost-share or services for which payment is disallowed for failure to comply with requirements for preauthorization or concurrent care review.

(b) The PHP agrees not to bill the beneficiary for services excluded on the basis of Chapter 4, paragraphs G.1. (not medically necessary), G.2. (inappropriate level of care) or G.7. (custodial care), unless the beneficiary has

agreed in writing to pay for the care, knowing the specific care in question had been determined noncovered by CHAMPUS. (A general statement signed at admission as to financial liability does not fulfill this requirement.)

m. Hospice programs. Hospice programs must be Medicare approved and meet all Medicare conditions of participation (42 CFR Part 418) in relation to CHAMPUS patients in order to receive payment under the CHAMPUS program. A hospice program may be found to be out of compliance with a particular Medicare condition of participation and still participate in the CHAMPUS as long as the hospice is allowed continued participation in Medicare while the condition of noncompliance is being corrected. The hospice program can be either a public agency or private organization (or a subdivision thereof) which:

(1) Is primarily engaged in providing the care and services described under Section 199.4(e)(19) and makes such services available on a 24-hour basis.

(2) Provides bereavement counseling for the immediate family or terminally ill individuals.

(3) Provides for such care and services in individuals' homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the hospice program, except that the agency or organization must:

(a) Ensure that substantially all the core services are routinely provided directly by hospice employees.

(b) Maintain professional management responsibility for all services which are not directly furnished to the patient, regardless of the location or facility in which the services are rendered.

(c) Provide assurances that the aggregate number of days of inpatient care provided in any 12-month period does not exceed 20 percent of the aggregate number of days of hospice care during the same period.

(d) Have an interdisciplinary group composed of the following personnel who provide the care and services described under Chapter 4.E.19 and who establish the policies governing the provision of such care/services:

1 a physician;

2 a registered professional nurse;

3 a social worker; and

4 a pastoral or other counselor.

(e) Maintain central clinical records on all patients.

(f) Utilize volunteers.

(g) The hospice and all hospice employees must be licensed in accordance with applicable Federal, State and local laws and regulations.

(h) The hospice must enter into an agreement with CHAMPUS in order to be qualified to participate and to be eligible for payment under the program. In this agreement the hospice and CHAMPUS agree that the hospice will:

1 Not charge the beneficiary or any other person for items or services for which the beneficiary is entitled to have payment made under the CHAMPUS hospice benefit.

2 Be allowed to charge the beneficiary for items or services requested by the beneficiary in addition to those that are covered under the CHAMPUS hospice benefit.

(i) Meet such other requirements as the Secretary of Defense may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization.

C. INDIVIDUAL PROFESSIONAL PROVIDERS OF CARE

1. General. Individual professional providers of care are those providers who bill for their services on a fee-for-service basis and are not employed or

under a contract which provides for payment to the individual professional provider by an institutional provider. This category also includes those individuals who have formed professional corporations or associations qualifying as a domestic corporation under section 301.7701-5 of the Internal Revenue Service Regulations (reference (cc)). Such individual professional providers must be licensed or certified by the local licensing or certifying agency for the jurisdiction in which the care is provided; or in the absence of state licensure/certification, be a member of or demonstrate eligibility for full clinical membership in, the appropriate national or professional certifying association that sets standards for the profession of which the provider is a member. Services provided must be in accordance with good medical practice and prevailing standards of quality of care and within recognized utilization norms.

a. Licensing/Certification required, scope of license. Otherwise covered services shall be cost-shared only if the individual professional provider holds a current, valid license or certification to practice his or her profession in the jurisdiction where the service is rendered. Licensure/certification must be at the full clinical practice level. The services provided must be within the scope of the license, certification or other legal authorization. Licensure or certification is required to be a CHAMPUS authorized provider if offered in the jurisdiction where the service is rendered, whether such licensure or certification is required by law or provided on a voluntary basis. The requirement also applies for those categories of providers that would otherwise be exempt by the state because the provider is working in a non-profit, state-owned or church setting. Licensure/certification is mandatory for a provider to become a CHAMPUS-authorized provider.

b. Monitoring required. The Director, OCHAMPUS, or a designee, shall develop appropriate monitoring programs and issue guidelines, criteria, or norms necessary to ensure that CHAMPUS expenditures are limited to necessary medical supplies and services at the most reasonable cost to the government and beneficiary. The Director, OCHAMPUS, or a designee, also will take such steps as necessary to deter overutilization of services.

c. Christian Science. Christian Science practitioners and Christian Science nurses are authorized to provide services under CHAMPUS. Inasmuch as they provide services of an extramedical nature, the general criteria outlined above do not apply to Christian Science services (refer to subparagraph C.3.d.(2), below, regarding services of Christian Science practitioners and nurses).

d. Physician referral and supervision. Physician referral and supervision is required for the services of paramedical providers as listed in subparagraph C.3.c.8. and for pastoral counselors, and mental health counselors. Physician referral means that the physician must actually see the patient, perform an evaluation, and arrive at an initial diagnostic impression prior to referring the patient. Documentation is required of the physician's examination, diagnostic impression, and referral. Physician supervision means that the physician provides overall medical management of the case. The physician does not have to be physically located on the premises of the provider to whom the referral is made. Communication back to the referring physician is an indication of medical management.

e. Medical records: Individual professional providers must maintain adequate clinical records to substantiate that specific care was actually furnished, was medically necessary, and appropriate, and identify(ies) the individual(s) who provided the care. This applies whether the care is inpatient or outpatient. The minimum requirements for medical record documentation are set forth by the following:

- (1) The cognizant state licensing authority;
- (2) The Joint Commission on Accreditation of Healthcare Organizations, or other health care accreditation organizations as may be appropriate;
- (3) Standards of practice established by national medical organizations; and
- (4) This Regulation.

2. Interns and residents. Interns and residents may not be paid directly by CHAMPUS for services rendered to a beneficiary when their services are provided as part of their employment (either salaried or contractual) by a hospital or other institutional provider.

3. Types of providers. Subject to the standards of participation provisions of this Regulation, the following individual professional providers of medical care are authorized to provide services to CHAMPUS beneficiaries:

a. Physicians

- (1) Doctors of Medicine (M.D.).
- (2) Doctors of Osteopathy (D.O.).

b. Dentists. Except for covered oral surgery as specified in section E. of Chapter 4 of this Regulation, all otherwise covered services rendered by dentists require preauthorization.

- (1) Doctors of Dental Medicine (D.M.D.).
- (2) Doctors of Dental Surgery (D.D.S.).

c. Other allied health professionals. The services of the following individual professional providers of care are coverable on a fee-for-service basis provided such services are otherwise authorized in this or other chapters of this Regulation.

(1) Clinical psychologist. For purposes of CHAMPUS, a clinical psychologist is an individual who is licensed or certified by the state for the independent practice of psychology and:

(a) Possesses a doctoral degree in psychology from a regionally accredited university; and

(b) Has had 2 years of supervised clinical experience in psychological health services of which at least 1 year is post-doctoral and 1 year (may be the post-doctoral year) is in an organized psychological health service training program; or

(c) As an alternative to (a) and (b) above, is listed in the National Register of Health Service Providers in Psychology (reference (ee)).

- (2) Doctors of Optometry.
- (3) Doctors of Podiatry or Surgical Chiropody.
- (4) Certified nurse midwives.

(a) A certified nurse midwife may provide covered care independent of physician referral and supervision, provided the nurse midwife is:

1 Licensed, when required, by the local licensing agency for the jurisdiction in which the care is provided; and

2 Certified by the American College of Nurse Midwives. To receive certification, a candidate must be a registered nurse who has completed successfully an educational program approved by the American College of Nurse Midwives, and passed the American College of Nurse Midwives National Certification Examination.

(b) The services of a registered nurse who is not a certified nurse midwife may be authorized only when the patient has been referred for care by a licensed physician and a licensed physician provides continuing supervision of the course of care. A lay midwife who is neither a certified nurse midwife nor a registered nurse is not a CHAMPUS-authorized provider, regardless of whether the services rendered may otherwise be covered.

(5) Certified nurse practitioner. Within the scope of applicable licensure or certification requirements, a certified nurse practitioner may provide covered care independent of physician referral and supervision, provided the nurse practitioner is:

(a) A licensed, registered nurse; and

(b) Specifically licensed or certified as a nurse practitioner by the state in which the care was provided, if the state offers such specific licensure or certification; or

(c) Certified as a nurse practitioner (certified nurse) by a professional organization offering certification in the speciality of practice, if the state does not offer specific licensure or certification for nurse practitioners.

(6) Certified Clinical Social Worker. A clinical social worker may provide covered services independent of physician referral and supervision, provided the clinical social worker:

(a) Is licensed or certified as a clinical social worker by the jurisdiction where practicing; or, if the jurisdiction does not provide for licensure or certification of clinical social workers, is certified by a national professional organization offering certification of clinical social workers; and

(b) Has at least a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education; and

(c) Has had a minimum of 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting, as determined by the Director, OCHAMPUS, or a designee.

NOTE: Patients' organic medical problems must receive appropriate concurrent management by a physician.

(7) Certified psychiatric nurse specialist. A certified psychiatric nurse specialist may provide covered care independent of physician referral and supervision. For purposes of CHAMPUS, a certified psychiatric nurse specialist is an individual who:

(a) Is a licensed, registered nurse; and

(b) Has at least a master's degree in nursing from a regionally accredited institution with a specialization in psychiatric and mental health nursing; and

(c) Has had at least 2 years of post-master's degree practice in the field of psychiatric and mental health nursing, including an average of 8 hours of direct patient contact per week; or

(d) Is listed in a CHAMPUS-recognized, professionally sanctioned listing of clinical specialists in psychiatric and mental health nursing.

(8) Certified physician assistant. A physician assistant may provide care under general supervision of a physician (see Chapter 14 G.I.C. for limitations on reimbursement). For purposes of CHAMPUS, a physician assistant must meet the applicable state requirements governing the qualifications of physician assistants and at least one of the following conditions:

(a) Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians, or

(b) Has satisfactorily completed a program for preparing physician assistants that:

1 Was at least 1 academic year in length;

2 Consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and

3 Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or

(c) Has satisfactorily completed a formal educational program for preparing physician assistants that does not meet the requirements of subparagraph (1)(b) of this paragraph and had been assisting primary care physicians for a minimum of 12 months during the 18-month period immediately preceding January 1, 1987.

(9) Other individual paramedical providers. The services of the following individual professional providers of care to be considered for benefits on a fee-for-service basis may be provided only if the beneficiary is referred by a physician for the treatment of a medically-diagnosed condition and a physician must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by these individual paramedical providers.

- (a) Licensed registered nurses.
- (b) Licensed practical or vocational nurses.
- (c) Licensed registered physical therapists.
- (d) Audiologists.
- (e) Speech therapists (speech pathologists).

d. Extramedical individual providers. Extramedical individual providers are those who do counseling or nonmedical therapy and whose training and therapeutic concepts are outside the medical field. The services of extramedical individual professionals are coverable following the CHAMPUS determined allowable charge methodology provided such services are otherwise authorized in this or other chapters of the regulation.

(1) Certified marriage and family therapists. For the purposes of CHAMPUS, a certified marriage and family therapist is an individual who meets the following requirements:

(a) Recognized graduate professional education with the minimum of an earned master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline; and

(b) The following experience:

1 Either 200 hours of approved supervision in the practice of marriage and family counseling, ordinarily to be completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases; and

2 1,000 hours of clinical experience in the practice of marriage and family counseling under approved supervision, involving at least 50 different cases; or

3 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years; and

4 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in marriage and family counseling under approved supervision, involving at least 20 cases; and

(c) Is licensed or certified to practice as a marriage and family therapist by the jurisdiction where practicing (see C.3.d.(4) of this part for more specific information regarding licensure); and

(d) Agrees that a patients' organic medical problems must receive appropriate concurrent management by a physician.

(e) Agrees to accept the CHAMPUS determined allowable charge as payment in full, except for applicable deductibles and cost-shares, and hold CHAMPUS beneficiaries harmless for noncovered care (i.e., may not bill a beneficiary for noncovered care, and may not balance bill a beneficiary for amounts above the allowable charge). The certified marriage and family therapist must enter into a participation agreement with the Office of CHAMPUS within which the certified marriage and family therapist agrees to all provisions specified above.

(f) As of the effective date of termination, the certified marriage and family therapist, will no longer be recognized as an authorized provider under CHAMPUS. Subsequent to termination, the certified marriage and family therapist may only be reinstated as an authorized CHAMPUS extramedical provider by entering into a new participation agreement as a certified marriage and family therapist.

(2) Pastoral counselors. For the purposes of CHAMPUS a pastoral counselor is an individual who meets the following requirements:

(a) Recognized graduate professional education with the minimum of an earned master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline; and

(b) The following experience:

1 Either 200 hours of approved supervision in the practice of pastoral counseling, ordinarily to be completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases; and

2 1,000 hours of clinical experience in the practice of pastoral counseling under approved supervision, involving at least 50 different cases; or

3 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of pastoral counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years; and

4 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in pastoral counseling under approved supervision, involving at least 20 cases; and

(c) Is licensed or certified to practice by the jurisdiction where practicing (see C.3.d.(4) of this part for more specific information regarding licensure); and

(d) The services of a pastoral counselor meeting the above requirements are coverable following the CHAMPUS determined allowable charge methodology, under the following specified conditions:

1 The CHAMPUS beneficiary must be referred for therapy by a physician; and

2 A physician is providing ongoing oversight and supervision of the therapy being provided; and

3 The pastoral counselor must certify on each claim for reimbursement that a written communication has been made or will be made to the referring physician of the results of the treatment. Such communication will be made at the end of the treatment, or more frequently, as required by the referring physician (refer to Chapter 7).

(e) Because of the similarity of the requirements for licensure, certification, experience and education a pastoral counselor may elect to be authorized under CHAMPUS as a certified marriage and family therapist, and as such, be subject to all previously defined criteria for the certified marriage and family therapist category, to include acceptance of the CHAMPUS determined allowable charge as payment in full, except for applicable deductibles and cost-shares, (i.e., balance billing of a beneficiary above the allowable charge is prohibited; may not bill beneficiary for noncovered care). The pastoral counselor must also agree to enter into the same participation agreement as a certified marriage and family therapist with the Office of CHAMPUS within which the pastoral counselor agrees to all provisions, including licensure, national association membership and conditions upon termination, outlined above for certified marriage and family therapists.

NOTE: No dual status will be recognized by the Office of CHAMPUS. Pastoral counselors must elect to become one of the categories of extramedical CHAMPUS providers specified above. Once authorized as either a pastoral counselor,

or a certified marriage and family therapist, claims review and reimbursement will be in accordance with the criteria established for the elected provider category.

(3) Mental Health Counselor. For the purposes of CHAMPUS, a mental health counselor is an individual who meets the following requirements:

(a) Minimum of a master's degree in mental health counseling or allied mental health field from a regionally accredited institution; and

(b) Two years of post-master's experience which includes 3000 hours of clinical work and 100 hours of face-to-face supervision; and

(c) Is licensed or certified to practice as a mental health counselor by the jurisdiction where practicing (see C.3.d.(4) of this part for more specific information); and

(d) May only be reimbursed when:

1 The CHAMPUS beneficiary is referred for therapy by a physician; and

2 A physician is providing ongoing oversight and supervision of the therapy being provided; and

3 The mental health counselor certifies on each claim for reimbursement that a written communication has been made or will be made to the referring physician of the results of the treatment. Such communication will be made at the end of the treatment, or more frequently, as required by the referring physician (refer to Chapter 7).

(4) The following additional information applies to each of the above categories of extramedical individual providers:

(a) These providers must also be licensed or certified to practice as a certified marriage and family therapist, pastoral counselor or mental health counselor by the jurisdiction where practicing. In jurisdictions that do not provide for licensure or certification, the provider must be certified by or eligible for full clinical membership in the appropriate national professional association that sets standards for the specific profession.

(b) Grace period for therapists or counselors in states where licensure/certification is optional. CHAMPUS is providing a grace period for those therapists or counselors who did not obtain optional licensure/certification in their jurisdiction, not realizing it was a CHAMPUS requirement for authorization. The exemption by state law for pastoral counselors may have misled this group into thinking licensure was not required. The same situation may have occurred with the other therapist or counselor categories. This grace period pertains only to the licensure/certification requirement, applies only to therapists or counselors who

are already approved as of October 29, 1990, and only in those areas where the licensure/certification is optional. Any therapist or counselor who is not licensed/certified in the state in which he/she is practicing by August 1, 1991, will be terminated under the provisions of Section 199.9 of this part. This grace period does not change any of the other existing requirements which remain in effect. During this grace period, membership or proof of eligibility for full clinical membership in a recognized professional association is required for those therapists or counselors who are not licensed or certified by the state. The following organizations are recognized for therapists or counselors at the level indicated: full clinical member of the American Association of Marriage and Family Therapy; membership at the fellow or diplomate level of the American Association of Pastoral Counselors; and membership in the National Academy of Certified Clinical Mental Health Counselors. Acceptable proof of eligibility for membership is a letter from the appropriate certifying organization. This opportunity for delayed certification/licensure is limited to the counselor or therapist category only as the language in all of the other provider categories has been consistent and unmodified from the time each of the other provider categories were added. The grace period does not apply in those states where licensure is mandatory.

(5) Christian Science practitioners and Christian Science nurses. CHAMPUS cost shares the services of Christian Science practitioners and nurses. In order to bill as such, practitioners or nurses must be listed or be eligible for listing in the Christian Science Journal at the time the service is provided.

D. OTHER PROVIDERS

Certain medical supplies and services of an ancillary or supplemental nature are coverable by CHAMPUS, subject to certain controls. This category of provider includes the following:

1. Independent laboratory. Laboratory services of independent laboratories may be cost-shared if the laboratory is approved for participation under Medicare and certified by the Medicare Bureau, Health Care Financing Administration.

2. Suppliers of portable x-ray services. Such suppliers must meet the conditions of coverage of the Medicare program, set forth in the Medicare regulations (reference (h)), or the Medicaid program in that state in which the covered service is provided.

3. Pharmacies. Pharmacies must meet the applicable requirements of state law in the state in which the pharmacy is located.

4. Ambulance companies. Such companies must meet the requirements of state and local laws in the jurisdiction in which the ambulance firm is licensed.

5. Medical equipment firms, medical supply firms. As determined by the Director, OCHAMPUS, or a designee.

6. Mammography Suppliers. Mammography services may be cost-shared only if the supplier is certified by Medicare for participation as a mammography supplier, or is certified by the American College of Radiology as having met its mammography supplier standards.

E. IMPLEMENTING INSTRUCTIONS

The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this chapter.

F. EXCLUSION

Regardless of any provision in this chapter, a provider who is suspended, excluded, or terminated under Chapter 9 of this Regulation is specifically excluded as an authorized CHAMPUS provider.

CHAPTER 14
PROVIDER REIMBURSEMENT METHODS

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G. Reimbursement of hospice programs. Hospice care will be reimbursed at one of four predetermined national CHAMPUS rates based on the type and intensity of services furnished to the beneficiary. A single rate is applicable for each day of care except for continuous home care where payment is based on the number of hours of care furnished during a 24-hour period. These rates will be adjusted for regional differences in wages using wage indices for hospice care.

1. National hospice rates. CHAMPUS will use the national hospice rates for reimbursement of each of the following levels of care provided by or under arrangement with a CHAMPUS approved hospice program:

a. Routine home care. The hospice will be paid the routine home care rate for each day the patient is at home, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

b. Continuous home care. The hospice will be paid the continuous home care rate when continuous home care is provided. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate.

(1) A minimum of 8 hours of care must be provided within a 24-hour day starting and ending at midnight.

(2) More than half of the total actual hours being billed for each 24-hour period must be provided by either a registered or licensed practical nurse.

(3) Homemaker and home health aide services may be provided to supplement the nursing care to enable the beneficiary to remain at home.

(4) For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day.

c. Inpatient respite care. The hospice will be paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care.

(1) Payment for respite care may be made for a maximum of 5 days at a time, including the date of admission but not counting the date of discharge. The necessity and frequency of respite care will be determined by the hospice interdisciplinary group with input from the patient's attending physician and the hospice's medical director.

(2) Payment for the sixth and any subsequent days is to be made at the routine home care rate.

d. General inpatient care. Payment at the inpatient rate will be made when general inpatient care is provided for pain control or acute or chronic symptom management which cannot be managed in other settings. None of the other

fixed payment rates (i.e., routine home care) will be applicable for a day on which the patient receives general inpatient care except on the date of discharge.

e. Date of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

2. Use of Medicare rates. CHAMPUS will use the most current Medicare rates to reimburse hospice programs for services provided to CHAMPUS beneficiaries. It is CHAMPUS' intent to adopt changes in the Medicare reimbursement methodology as they occur; e.g., Medicare's adoption of an updated, more accurate wage index.

3. Physician reimbursement. Payment is dependent on the physician's relationship with both the beneficiary and the hospice program.

a. Physicians employed by, or contracted with, the hospice.

(1) Administrative and supervisory activities (i.e., establishment, review and updating of plans of care, supervising care and services, and establishing governing policies) are included in the adjusted national payment rate.

(2) Direct patient care services are paid in addition to the adjusted national payment rate.

(a) Physician services will be reimbursed an amount equivalent to 100 percent of the CHAMPUS' allowable charge; i.e., there will be no cost-sharing and/or deductibles for hospice physician services.

(b) Physician payments will be counted toward the hospice cap limitation.

b. Independent attending physician. Patient care services rendered by an independent attending physician (a physician who is not considered employed by or under contract with the hospice) are not part of the hospice benefit.

(1) Attending physician may bill in his/her own right.

(2) Services will be subject to the appropriate allowable charge methodology.

(3) Reimbursement is not counted toward the hospice cap limitation.

(4) Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.

(5) The hospice must notify the CHAMPUS contractor of the name of the physician whenever the attending physician is not a hospice employee.

c. Voluntary physician services. No payment will be allowed for physician services furnished voluntarily (both physicians employed by, and under contract with, the hospice and independent attending physicians). Physicians may not discriminate against CHAMPUS beneficiaries; e.g., designate all services rendered to non-CHAMPUS patients as volunteer and at the same time bill for CHAMPUS patients.

4. Unrelated medical treatment. Any covered CHAMPUS services not related to the treatment of the terminal condition for which hospice care was elected will be paid in accordance with standard reimbursement methodologies; i.e., payment for these services will be subject to standard deductible and cost-sharing provisions under the CHAMPUS. A determination must be made whether or not services provided are related to the individual's terminal illness. Many illnesses may occur when an individual is terminally ill which are brought on by the underlying condition of the patient. For example, it is not unusual for a terminally ill patient to develop pneumonia or some other illness as a result of his or her weakened condition. Similarly, the setting of bones after fractures occur in a bone cancer patient would be treatment of a related condition. Thus, if the treatment or control of an upper respiratory tract infection is due to the weakened state of the terminal patient, it will be considered a related condition, and as such, will be included in the hospice daily rates.

5. Cap amount. Each CHAMPUS-approved hospice program will be subject to a cap on aggregate CHAMPUS payments from November 1 through October 31 of each year, hereafter known as "the cap period."

a. The cap amount will be adjusted annually by the percent of increase or decrease in the medical expenditure category of the Consumer Price Index for all urban consumers (CPI-U).

b. The aggregate cap amount (i.e., the statutory cap amount times the number of CHAMPUS beneficiaries electing hospice care during the cap period) will be compared with total actual CHAMPUS payments made during the same cap period.

c. Payments in excess of the cap amount must be refunded by the hospice program. The adjusted cap amount will be obtained from the Health Care Financing Administration (HCFA) prior to the end of each cap period.

d. Calculation of the cap amount for a hospice which has not participated in the program for an entire cap year (November 1 through October 31) will be based on a period of at least 12 months but no more than 23 months.

For example, the first cap period for a hospice entering the program on October 1, 1994, would run from October 1, 1994 through October 31, 1995. Similarly, the first cap period for hospice providers entering the program after November 1, 1993 but before November 1, 1994 would end October 31, 1995.

6. Inpatient limitation. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days, both for general inpatient care and respite care, may not exceed 20 percent of the aggregate total number of days of hospice care provided to all CHAMPUS beneficiaries during the same period.

a. If the number of days of inpatient care furnished to CHAMPUS beneficiaries exceeds 20 percent of the total days of hospice care to CHAMPUS beneficiaries, the total payment for inpatient care is determined as follows:

(1) Calculate the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the hospice to Medicare patients.

(2) Multiply this ratio by the total reimbursement for inpatient care made by the CHAMPUS contractor.

(3) Multiply the number of actual inpatient days in excess of the limitation by the routine home care rate.

(4) Add the amounts calculated in paragraphs G.6.a.(2) and (3) of this section.

b. Compare the total payment for inpatient care calculated in paragraph G.6.a.(4) above to actual payments made to the hospice for inpatient care during the cap period.

c. Payments in excess of the inpatient limitation must be refunded by the hospice program.

7. Hospice reporting responsibilities. The hospice is responsible for reporting the following data within 30 days after the end of the cap period:

a. Total reimbursement received and receivable for services furnished CHAMPUS beneficiaries during the cap period, including physician's services not of an administrative or general supervisory nature.

b. Total reimbursement received and receivable for general inpatient care and inpatient respite care furnished to CHAMPUS beneficiaries during the cap period.

c. Total number of inpatient days furnished to CHAMPUS hospice patients (both general inpatient and inpatient respite days) during the cap period.

d. Total number of CHAMPUS hospice days (both inpatient and home care) during the cap period.

e. Total number of beneficiaries electing hospice care. The following rules must be adhered to by the hospice in determining the number of CHAMPUS beneficiaries who have elected hospice care during the period:

(1) The beneficiary must not have been counted previously in either another hospice's cap or another reporting year.

(2) The beneficiary must file an initial election statement during the period beginning September 28 of the previous cap year through September 27 of the current cap year in order to be counted as an electing CHAMPUS beneficiary during the current cap year.

(3) Once a beneficiary has been included in the calculation of a hospice cap amount, he or she may not be included in the cap for that hospice again, even if the number of covered days in a subsequent reporting period exceeds that of the period where the beneficiary was included.

(4) There will be proportional application of the cap amount when a beneficiary elects to receive hospice benefits from two or more different CHAMPUS-certified hospices. A calculation must be made to determine the percentage of the patient's length of stay in each hospice relative to the total length of hospice stay.

8. Reconsideration of cap amount and inpatient limit. A hospice dissatisfied with the contractor's calculation and application of its cap amount and/or inpatient limitation may request and obtain a contractor review if the amount of program reimbursement in controversy -- with respect to matters which the hospice has a right to review -- is at least \$1000. The administrative review by the contractor of the calculation and application of the cap amount and inpatient limitation is the only administrative review available. These calculations are not subject to the appeal procedures set forth in Chapter 10. The methods and standards for calculation of the hospice payment rates established by CHAMPUS, as well as questions as to the validity of the applicable law, regulations or CHAMPUS decisions, are not subject to administrative review, including the appeal procedures of Chapter 10.

9. Beneficiary cost-sharing. There are no deductibles under the CHAMPUS hospice benefit. CHAMPUS pays the full cost of all covered services for the terminal illness, except for small cost-share amounts which may be collected by the individual hospice for outpatient drugs and biologicals and inpatient respite care.

a. The patient is responsible for 5 percent of the cost of outpatient drugs or \$5 toward each prescription, whichever is less. Additionally, the cost of prescription drugs (drugs or biologicals) may not exceed that which a prudent

buyer would pay in similar circumstances; that is, a buyer who refuses to pay more than the going price for an item or service and also seeks to economize by minimizing costs.

b. For inpatient respite care, the cost-share for each respite care day is equal to 5 percent of the amount CHAMPUS has estimated to be the cost of respite care, after adjusting the national rate for local wage differences.

c. The amount of the individual cost-share liability for respite care during a hospice cost-share period may not exceed the Medicare inpatient hospital deductible applicable for the year in which the hospice cost-share period began. The individual hospice cost-share period begins on the first day an election is in effect for the beneficiary and ends with the close of the first period of 14 consecutive days on each of which an election is not in effect for the beneficiary.

H. REIMBURSEMENT OF INDIVIDUAL HEALTH-CARE PROFESSIONALS AND OTHER NON-INSTITUTIONAL HEALTH-CARE PROVIDERS

The CHAMPUS-determined reasonable charge (the amount allowed by CHAMPUS) for the service of an individual health-care professional or other non-institutional health-care provider (even if employed by or under contract to an institutional provider) shall be determined by one of the following methodologies, that is, whichever is in effect in the specific geographic location at the time covered services and supplies are provided to a CHAMPUS beneficiary.

1. Allowable charge method.

a. Introduction

(1) In general. The allowable charge method is the preferred and primary method for reimbursement of individual health care professionals and other non-institutional health care providers (covered by 10 U.S.C. 1079(h)(1)). The allowable charge for authorized care shall be the lower of the billed charge or the local CHAMPUS Maximum Allowable Charge (CMAC) level.

(2) CHAMPUS Maximum Allowable Charge. Beginning in calendar year 1992, prevailing charge levels and appropriate charge levels will be calculated on a national level. There will then be calculated a national CHAMPUS Maximum Allowable Charge (CMAC) level for each procedure, which shall be the lesser of the national prevailing charge level or the national appropriate charge level. The national CMAC will then be adjusted for localities in accordance with paragraph G.1.d., of this Chapter.

(3) Differential for Participating Providers. Beginning in calendar year 1994, there shall be a differential in national and local CMACs based on whether the provider is a participating provider or a nonparticipating provider. The differential shall be calculated so that the CMAC for the nonparticipating providers is 95 percent of the CMAC for the participating providers. To assure the effectiveness of the several phase-in and waiver

provisions set forth in paragraphs G.1.c., and G.1.d., of this Chapter, beginning in calendar year 1994, there will first be calculated the national and local CMACs for nonparticipating providers. For purposes of this calculation, the identification of overpriced procedures called for in paragraph G.1.C.a., of this Chapter and the calculation of appropriate charge levels for such overpriced procedures called for in paragraph G.1.D.(2), of this Chapter shall use as the Medicare fee component of the comparisons and calculations the fee level applicable to Medicare nonparticipating providers, which is 95 percent of the basic fee level. After nonparticipating provider local CMACs are calculated (including consideration of special phase-in rules and waiver rules in paragraph G.1.d., of this Chapter) participating provider local CMACs will be calculated so that nonparticipating provider local CMACs are 95 percent of participating provider local CMACs. (For more information on the Participating Provider Program, see Chapter 6.A.8).

(4) Limits on balance billing by nonparticipating providers.

Nonparticipating providers may not balance bill a beneficiary an amount which exceeds the applicable balance billing limit. The balance billing limit shall be the same percentage as the Medicare limiting charge percentage for nonparticipating physicians. The balance billing limit may be waived by the Director, OCHAMPUS on a case-by-case basis if requested by the CHAMPUS beneficiary (or sponsor) involved. A decision by the Director to waive or not waive the limit in any particular case is not subject to the appeal and hearing procedures of Chapter 10., of this regulation.

b. Prevailing charge level.

(1) Beginning in calendar year 1992, the prevailing charge level shall be calculated on a national basis.

(2) The national prevailing charge level referred to in paragraph G.1.b.(1) of this section is the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period. The 80th percentile of charges shall be determined on the basis of statistical data and methodology acceptable to the Director, OCHAMPUS (or a designee).

(3) For purposes of paragraph G.1.b.(2) of this section, the base period shall be a period of 12 calendar months and shall be adjusted once a year, unless the Director, OCHAMPUS determines that a different period for adjustment is appropriate and publishes a notice to that effect in the Federal Register.

c. Appropriate charge level. Beginning in calendar year 1992, the appropriate charge level for each procedure is the product of the two-step process set forth in paragraphs G.1.(c)(1) and (2) of this Chapter. This process involves comparing the prior year's CMAC with the fully phased in Medicare fee. For years after the Medicare fee has been fully phased in, the comparison shall be to the current Medicare fee. For any particular procedure

for which comparable Medicare fee and CHAMPUS data are unavailable, but for which alternative data are available that the Director, OCHAMPUS (or designee) determines provide a reasonable approximation of relative value or price, the comparison may be based on such alternative data.

(1) Step 1: procedures classified. All procedures are classified into one of three categories, as follows:

(a) Overpriced procedures. These are the procedures for which the prior year's national CMAC exceeds the Medicare fee.

(b) Other procedures. These are procedures subject to the allowable charge method that are not included in either the overpriced procedures group or the underpriced procedures group.

(c) Underpriced procedures. These are the procedures for which the prior year's national CMAC is less than the Medicare fee.

(2) Step 2: calculating appropriate charge levels. For each year, appropriate charge levels will be calculated by adjusting the prior year's CMAC as follows:

(a) For overpriced procedures, the appropriate charge level for each procedure shall be the prior year's CMAC, reduced by the lesser of: the percentage by which it exceeds the Medicare fee or fifteen percent.

(b) For other procedures, the appropriate charge level for each procedure shall be the same as the prior year's CMAC.

(c) For underpriced procedures, the appropriate charge level for each procedure shall be the prior year's CMAC, increased by the lesser of: the percentage by which it is exceeded by the Medicare fee or the Medicare Economic Index.

c. Special rule for cases in which the CHAMPUS appropriate charge was prematurely reduced. In any case in which a recalculation of the Medicare fee results in a Medicare rate higher than the CHAMPUS appropriate charge for a procedure that had been considered an overpriced procedure, the reduction in the CHAMPUS appropriate charge shall be restored up to the level of the recalculated Medicare rate.

d. Calculating CHAMPUS Maximum Allowable Charge levels for localities.

(1) In general. The national CHAMPUS Maximum Allowable Charge level for each procedure will be adjusted for localities using the same (or similar) geographical areas and the same geographic adjustment factors as are used for determining allowable charges under Medicare.

(2) Special locality-based phase-in provision.

(a) In general. Beginning with the recalculation of CMACs for calendar year 1993, the CMAC in a locality will not be less than 72.25 percent of the maximum charge level in effect for that locality on December 31, 1991. For recalculations of CMACs for calendar years after 1993, the CMAC in a locality will not be less than 85 percent of the CMAC in effect for that locality at the end of the prior calendar year.

(b) Exception. The special locality-based phase-in provision established by Section G.1.d.(2)(a) of this Chapter shall not be applicable in the case of any procedure code for which there were not CHAMPUS claims in the locality accounting for at least 50 services.

(3) Special locality-based waivers of reductions to assure adequate access to care. Beginning with the recalculation of CMACs for calendar year 1993, in the case of any procedure classified as an overpriced procedure pursuant to section G.1.c.(1)(a) of this Chapter, a reduction in the CMAC in a locality below the level in effect at the end of the previous calendar year that would otherwise occur pursuant to sections G.1.c., and G.1.d., of this Chapter may be waived pursuant to this section G.1.c.(3).

(a) Waiver based on balance billing rates. Except as provided in section G.1.d.(3)(b) of this Chapter such a reduction will be waived if there has been excessive balance billing in the locality for the procedure involved. For this purpose, the extent of balance billing will be determined based on a review of all services under the procedure code involved in the prior year (or most recent period for which data are available). If the number of services for which balance billing was not required was less than 60 percent of all services provided, the Director will determine that there was an excessive balance billing with respect to that procedure in that locality and will waive the reduction in the CMAC that would otherwise occur. A decision by the Director to waive or not to waive the reduction is not subject to the appeal and hearing procedures of Chapter 10 of this regulation.

(b) Exception. As an exception to section G.1.d.(3)(a) of this Chapter, the waiver required by that section shall not be applicable in the case of any procedure code for which there were not CHAMPUS claims in the locality accounting for at least 50 services. A waiver may, however, be granted in such cases pursuant to section G.1.d.(3)(c) of this Chapter.

(c) Waiver based on other evidence that adequate access to care would be impaired. The Director, OCHAMPUS may waive a reduction that would otherwise occur (or restore a reduction that was already taken) if the Director determines that available evidence shows that the reduction would impair adequate access. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the number of such providers who are CHAMPUS Participating Providers, the number of CHAMPUS beneficiaries in the area, and other relevant factors. Providers or beneficiaries in a locality may submit to the Director, OCHAMPUS a petition, together with appropriate documentation regarding relevant factors, for a determination that adequate access would be impaired. The Director, OCHAMPUS will consider and respond to all such petitions. Petitions may be filed at any

time. Any petition received by the date which is 120 days prior to the implementation of a recalculation of CMACs will be assured of consideration prior that implementation. The Director, OCHAMPUS may establish procedures for handling petitions. A decision by the Director to waive or not to waive a reduction is not subject to the appeal and hearing procedures of Chapter 10 of this regulation.

e. Special rules for 1991.

(1) Prevailing charge levels for care provided on or after January 1, 1991, and before the 1992 prevailing charge levels take effect shall be the same as those in effect on December 31, 1990, except that prevailing charge levels for care provided on or after October 7, 1991 shall be those established pursuant to this paragraph G.1.e. of this section.

(2) Appropriate charge levels will be established for each locality for which a prevailing charge level was in effect immediately prior to October 7, 1991. For each procedure, the appropriate charge level shall be the prevailing charge level in effect immediately prior to October 7, 1991, adjusted as provided in G.1.e.(2)(a) through (c) of this section.

(a) For each overpriced procedure, the level shall be reduced by fifteen percent. For this purpose, overpriced procedures are the procedures determined by the Physician Payment Review Commission to be overvalued pursuant to the process established under the Medicare program, other procedures considered overvalued in the Medicare program (for which Congress directed reductions in Medicare allowable levels for 1991), radiology procedures and pathology procedures.

(b) For each other procedure, the level shall remain unchanged. For this purpose, other procedures are procedures which are not overpriced procedures or primary care procedures.

(c) For each primary care procedure, the level shall be adjusted by the MEI, as the MEI is applied to Medicare prevailing charge levels. For this purpose, primary care procedures include maternity care and delivery services and well baby care services.

f. Special transition rule for 1992.

(1) For purposes of calculating the national appropriate charge levels for 1992, the prior year's appropriate charge level for each service will be considered to be the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period of July 1, 1986 to June 30, 1987 (determined as under paragraph G.1.b.(2) of this section), adjusted to calendar year 1991 based on the adjustments made for maximum CHAMPUS prevailing charge levels through 1990 and the application of paragraph G.1.e. of this section for 1991.

(2) The adjustment to calendar year 1991 of the product of paragraph G.1.f.(1) of this section shall be as follows:

(a) For procedures other than those described in paragraph G.1.f.(2)(b) of this section, the adjustment to 1991 shall be on the same basis as that provided under paragraph G.1.e. of this section.

(b) For any procedure that was considered an overpriced procedure for purposes of the 1991 prevailing charge levels under paragraph G.1.e. of this section for which the resulting 1991 prevailing charge level was less than 150 percent of the Medicare converted relative value unit, the adjustment to 1991 for purposes of the special transition rule for 1992 shall be as if the procedure had been treated under paragraph G.1.e.(2)(b) of this section for purposes of the 1991 prevailing charge level.

g. Adjustments and procedural rules.

(1) The Director, OCHAMPUS may make adjustments to the appropriate charge levels calculated pursuant to paragraphs G.1.c. and G.1.e. of this section to correct any anomalies resulting from data or statistical factors, significant differences between Medicare-relevant information and CHAMPUS-relevant considerations or other special factors that fairness requires be specially recognized. However, no such adjustment may result in reducing an appropriate charge level.

(2) The Director, OCHAMPUS will issue procedural instructions for administration of the allowable charge method.

h. Clinical laboratory services. The allowable charge for clinical diagnostic laboratory test services shall be calculated in the same manner as allowable charges for other individual health care providers are calculated pursuant to paragraphs G.1.a. through G.1.d. of this Chapter, with the following exceptions and clarifications.

(1) The calculation of national prevailing charge levels, national appropriate charge levels and national CMACs for laboratory services shall begin in calendar year 1993. For purposes of the 1993 calculation, the prior year's national appropriate charge level or national prevailing charge level shall be the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the period July 1, 1991, through June 30, 1992 (referred to in this paragraph G.1.h. of this Chapter as the "base period").

(2) For purposes of comparison to Medicare allowable payment amounts pursuant to paragraph G.1.c. of this Chapter, the Medicare national laboratory payment limitation amounts shall be used.

(3) For purposes of establishing laboratory service local CMACs pursuant to paragraph G.1.d. of this Chapter, the adjustment factor shall equal the ratio of the local average charge (standardized for the distribution clinical laboratory services) to the national average charge for all clinical laboratory services during the base period.

(4) For purposes of a special locality-based phase-in provision similar to that established by paragraph G.1.d.(2) of this Chapter, the CMAC in a locality will not be less than 85 percent of the maximum charge level in effect for that locality during the base period.

i. The allowable charge for physician assistant services other than assistant-at-surgery may not exceed 85 percent of the allowable charge for a comparable service rendered by a physician performing the service in a similar location. For cases in which the physician assistant and the physician perform component services of a procedure other than assistant-at-surgery (e.g., home, office or hospital visit), the combined allowable charge for the procedure may not exceed the allowable charge for the procedure rendered by a physician alone. The allowable charge for physician assistant services performed as an assistant-at-surgery may not exceed 65 percent of the allowable charge for a physician serving as an assistant surgeon when authorized as CHAMPUS benefits in accordance with the provisions of Chapter 4 C.3.c. of this Part. Physician assistant services must be billed through the employing physician who must be an authorized CHAMPUS provider.

j. A charge that exceeds the CHAMPUS Maximum Allowable charge can be determined to be allowable only when unusual circumstances or medical complications justify the higher charge. The allowable charge may not exceed the billed charge under any circumstances.

2. All-inclusive rate. Claims from individual health-care professional providers for services rendered to CHAMPUS beneficiaries residing in an RTC that is either being reimbursed on an all-inclusive per diem rate, or is billing an all-inclusive per diem rate, shall be denied; with the exception of independent health-care professionals providing geographically distant family therapy to a family member residing a minimum of 250 miles from the RTC or covered medical services related to a nonmental health condition rendered outside the RTC. Reimbursement for individual professional services is included in the rate paid the institutional provider.

3. Alternative method. The Director, OCHAMPUS, or a designee, may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to ensure a high level of acceptance of the CHAMPUS-determined charge by the individual health-care professionals or other noninstitutional health-care providers furnishing services and supplies to CHAMPUS beneficiaries. Alternative methods may not result in reimbursement greater than the allowable charge method above.

I. REIMBURSEMENT UNDER THE MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM

The Military-Civilian Health Services Partnership Program, as authorized by Section 1096, Chapter 55, Title 10, provides for the sharing of staff, equipment, and resources between the civilian and military health care system in order to achieve more effective, efficient, or economical health care for authorized beneficiaries. Military treatment facility commanders, based upon

the authority provided by their respective Surgeons General of the military departments, are responsible for entering into individual partnership agreements only when they have determined specifically that use of the Partnership Program is more economical overall to the Government than referring the need for health care services to the civilian community under the normal operation of the CHAMPUS Program. (See Section P. of Chapter 1, for general requirements of the Partnership Program.)

1. Reimbursement of institutional health care providers. Reimbursement of institutional health care providers under the Partnership Program shall be on the same basis as non-Partnership providers.

2. Reimbursement of individual health-care professionals and other non-institutional health care providers. Reimbursement of individual health care professional and other non-institutional health care providers shall be on the same basis as non-Partnership providers as detailed in Section G. of this chapter.

J. ACCOMMODATION OF DISCOUNTS UNDER PROVIDER REIMBURSEMENT METHODS

1. General rule. The Director, OCHAMPUS (or designee) has authority to reimburse a provider at an amount below the amount usually paid pursuant to this chapter when, under a program approved by the Director, the provider has agreed to the lower amount.

2. Special applications. The following are examples of applications of the general rule; they are not all inclusive.

a. In the case of individual health care professionals and other noninstitutional providers, if the discounted fee is below the provider's normal billed charge and the prevailing charge level (see section G. of this chapter), the discounted fee shall be the provider's actual billed charge and the CHAMPUS allowable charge.

b. In the case of institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under subsection A.1. of this chapter or per-diem amount under subsection A.2. of this chapter), if the discount rate is lower than the pre-set rate, the discounted rate shall be the CHAMPUS-determined allowable cost. This is an exception to the usual rule that the pre-set rate is paid regardless of the institutional provider's billed charges or other factors.

3. Procedures.

a. This section only applies when both the provider and the Director have agreed to the discounted payment rate. The Director's agreement may be in the context of approval of a program that allows for such discounts.

b. The Director of OCHAMPUS may establish uniform terms, conditions and limitations for this payment method in order to avoid administrative complexity.

| K. OUTSIDE THE UNITED STATES

The Director, OCHAMPUS, or a designee, shall determine the appropriate reimbursement method or methods to be used in the extension of CHAMPUS benefits for otherwise covered medical services or supplies provided by hospitals or other institutional providers, physicians or other individual professional providers, or other providers outside the United States.

| L. IMPLEMENTING INSTRUCTIONS

The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this chapter.

CHAPTER 20

CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP)

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CHAPTER 20
CONTINUED HEALTH CARE BENEFIT PROGRAM

A. PURPOSE.

The CHCBP is a premium based temporary health care coverage program that will be available to qualified beneficiaries (set forth in paragraph D.1. of this section). Medical coverage under this program will mirror the benefits offered via the basic CHAMPUS program. Premium costs for this coverage are payable by enrollees to a Third Party Administrator. The CHCBP is not part of the CHAMPUS program. However, as set forth in this section, it functions under most of the rules and procedures of CHAMPUS. Because the purpose of the CHCBP is to provide a continuation health care benefit for DoD and the other Uniformed Services (e.g., NOAA, PHS, and the Coast Guard) health care beneficiaries losing eligibility, it will be administered so that it appears, to the maximum extent possible, to be part of CHAMPUS.

B. GENERAL PROVISIONS. Except for any provisions the Director, OCHAMPUS may exclude, the general provisions of section 199.1 shall apply to the CHCBP as they do to CHAMPUS.

C. DEFINITIONS. Except as may be specifically provided in this section, to the extent terms defined in section 199.2 are relevant to the administration of the CHCBP, the definitions contained in that section shall apply to the CHCBP as they do to CHAMPUS.

D. ELIGIBILITY AND ENROLLMENT.

1. Eligibility. Enrollment in the CHCBP is open to the following individuals:

(a) Members of Uniformed Services, who:

(1) Are discharged or released from active duty (or full time National Guard duty), whether voluntarily or involuntarily, under other than adverse conditions;

(2) Immediately preceding that discharge or release, were entitled to medical and dental care under 10 U.S.C. 1074(a) (except in the case of a member discharged or released from full-time National Guard duty); and,

(3) After that discharge or release and any period of transitional health care provided under 10 U.S.C. 1145(a) would not otherwise be eligible for any benefit under 10 U.S.C. chapter 55.

(b) A person who:

(1) Ceases to meet requirements for being considered an unmarried dependent child of a member or former member of the armed forces under 10 U.S.C. 1072(2)(D);

(2) On the day before ceasing to meet those requirements, was covered under a health benefits plan under 10 U.S.C. chapter 55, or transitional health care under 10 U.S.C. 1145(a) as a dependent of the member or former member; and,

(3) Would not otherwise be eligible for any benefits under 10 U.S.C chapter 55.

(c) A person who:

(1) Is an unremarried former spouse of a member or former member of the armed forces;

(2) On the day before the date of the final decree of divorce, dissolution, or annulment was covered under a health benefits plan under 10 U.S.C. chapter 55, or transitional health care under 10 U.S.C. chapter 58, section 1145(a) as a dependent of the member or former member; and,

(3) Is not a dependent of the member or former member under 10 U.S.C. 1072, subparagraphs (F) or (G) or ends a one-year period of dependency under 10 U.S.C. 1072(2), subparagraph (h).

2. Effective date. Except for the special transitional provisions in paragraph R. of this section, eligibility in the CHCBP is limited to individuals who lost their entitlement to regular military health services system benefits on or after October 1, 1994.

3. Notification of eligibility.

a. The Department of Defense and the other Uniformed Services (National Oceanic and Atmospheric Administration (NOAA), Public Health Service (PHS), Coast Guard) will notify persons eligible to receive health benefits under the CHCBP.

b. In the case of a member who becomes (or will become) eligible for continued coverage, the Department of Defense shall notify the member of their rights for coverage as part of preseparation counseling conducted under 10 U.S.C: 1142.

c. In the case of a child of a member or former member who becomes eligible for continued coverage:

(1) The member or former member may submit to the Third Party Administrator a notice of the child's change in status (including the child's name, address, and such other information needed; and

(2) The Third Party Administrator, within 14 days after receiving such information, will inform the child of the child's rights under section 1142.

d. In the case of a former spouse of a member or former member who becomes eligible for continued coverage, the Third Party Administrator will notify the individual of eligibility for CHCBP when he or she declares the change in marital status to a military personnel office.

4. Election of coverage.

a. In order to obtain continued coverage, written election by eligible beneficiary must be made, within a prescribed time period. In the case of a member discharged or released from active duty (or full time National Guard duty), whether voluntarily or involuntarily; an unremarried spouse of a member or former member; or a child emancipated from a member or former member, the written election shall be submitted to the Third Party Administrator before the end of the 60-day period beginning on the later of:

(1) The date of the discharge or release of the member from active duty or full-time National Guard duty;

(2) The date on which the period of transitional health care applicable to the member under 10 U.S.C. 1145(a) ends;

(3) In the case of an unremarried former spouse of a member or former member, the date the one-year extension of dependency under 10 U.S.C. 1072(2)(H) expires; or

(4) The date the member receives the notification of eligibility.

b. A member of the armed forces who is eligible for enrollment under paragraph (d)(1)(i) of this section may elect self-only or family coverage. Family members who may be included in such family coverage are the spouse and children of the member.

5. Enrollment. Enrollment in the Continued Health Care Benefit Program will be accomplished by submission of an application to a Third Party Administrator (TPA). Upon submittal of an application to the Third Party Administrator, the enrollee must submit proof of eligibility.

a. One of the following types of evidence will validate eligibility for care:

(1) A Defense Enrollment Eligibility Reporting System (DEERS) printout which indicates the appropriate sponsor status and the sponsor's and dependent's eligibility dates;

(2) A copy of a verified and approved DD Form 1172, "Application for Uniformed Services Identification and Privilege Card";

(3) A front and back copy of a DD Form 1173, "Uniformed Services Identification and Privilege Card" over stamped "TA" for Transition Assistance Management Program; or

(4) A copy of a DD Form 214 - "Certificate of Release or Discharge from Active Duty".

6. Period of coverage. CHCBP coverage may not extend beyond:

a. For a member discharged or released from active duty (or full time National Guard duty), whether voluntarily or involuntarily, the date which is 18 months after the date the member ceases to be entitled to care under 10 U.S.C. 1074(a) and any transitional care under 10 U.S.C. 1145.

b. In the case of an unmarried dependent child of a member or former member, the date which is 36 months after the date on which the person first ceases to meet the requirements for being considered an unmarried dependent child under 10 U.S.C 1072(2)(D).

c. In the case of an unremarried former spouse of a member or former member, the date which is 36 months after the later of:

(1) The date on which the final decree of divorce, dissolution, or annulment occurs; or

(2) If applicable, the date the one-year extension of dependency under 10 U.S.C. 1072(2)(H) expires.

d. In the case of an unremarried former spouse of a member or former member, whose divorce occurred prior to the end of transitional coverage, the period of coverage under the CHCBP is unlimited, if:

(1) Has not remarried before the age of 55; and

(2) Was enrolled in the CHCBP as the dependent of an involuntarily separated member during the 18-month period before the date of the divorce, dissolution, or annulment; and

(3) Is receiving a portion of the retired or retainer pay of the member or former member or an annuity based on the retainer pay of the member; or

(4) Has a court order for payment of any portion of the retired or retainer pay; or

(5) Has a written agreement (whether voluntary or pursuant to a court order) which provides for an election by the member or former member to provide an annuity to the former spouse.

e. For the beneficiary who becomes eligible for the Continued Health Care Benefit Program by ceasing to meet the requirements for being considered an unmarried dependent child of a member or former member, health care coverage may not extend beyond the date which is 36 months after the date the member becomes ineligible for medical and dental care under 10 U.S.C. 1074(a) and any transitional health care under 10 U.S.C. 1145(a).

f. Though beneficiaries have sixty-days (60) to elect coverage under the CHCBP, upon enrolling, the period of coverage must begin the day after entitlement to a military health care plan (including transitional health care under section 1145(a)) ends.

E. CHCBP BENEFITS.

1. In general. Except as provided in paragraph E.2. of this section, the provisions of section 199.4 shall apply to the CHCBP as they do to CHAMPUS.

2. Exceptions. The following provisions of section 199.4 are not applicable to the Continued Health Care Benefit Program:

a. Paragraph (a)(2) concerning eligibility:

b. All provisions regarding nonavailability statements or requirements to use facilities of the Uniformed Services.

3. Beneficiary liability. For purposes of CHAMPUS deductible and cost sharing requirements and catastrophic cap limits, amounts applicable to the categories of beneficiaries to which the CHCBP enrollee last belonged shall continue to apply, except that for separating active duty members, amounts applicable to dependents of active duty members shall apply.

F. AUTHORIZED PROVIDERS. The provisions of section 199.6 shall apply to the CHCBP as they do to CHAMPUS.

G. CLAIMS SUBMISSION, REVIEW, AND PAYMENT. The provisions of section 199.7 shall apply to the CHCBP as they do to CHAMPUS, except that no provisions regarding nonavailability statements shall apply.

H. DOUBLE COVERAGE. The provisions of section 199.8 shall apply to the CHCBP as they do to CHAMPUS.

I. FRAUD, ABUSE, AND CONFLICT OF INTEREST. Administrative remedies for fraud, abuse and conflict of interest. The provisions of section 199.9 shall apply to the CHCBP as they do to CHAMPUS.

J. APPEAL AND HEARING PROCEDURES. The provisions of section 199.10 shall apply to the CHCBP as they do to CHAMPUS.

K. OVERPAYMENT RECOVERY. The provisions of section 199.11 shall apply to the CHCBP as they do to CHAMPUS.

L. THIRD PARTY RECOVERIES. The provisions of section 199.12 shall apply to the CHCBP as they do to CHAMPUS.

M. PROVIDER REIMBURSEMENT METHODS. The provisions of section 199.14 shall apply to the CHCBP as they do to CHAMPUS.

N. PEER REVIEW ORGANIZATION PROGRAM. The provisions of section 199.15 shall apply to the CHCBP as they do to CHAMPUS.

O. PREFERRED PROVIDER ORGANIZATION PROGRAMS AVAILABLE. Any preferred provider organization program under this part that provides for reduced cost sharing for using designated providers, such as the "TRICARE Extra" option under section 199.17, shall be available to participants in the CHCBP as it is to CHAMPUS beneficiaries.

P. SPECIAL PROGRAMS NOT APPLICABLE.

1. In general. Special programs established under this Part that are not part of the basic CHAMPUS program established pursuant to 10 U.S.C. 1079 and 1086 are not, unless specifically provided in this section, available to participants in the CHCBP.

2. Examples. The special programs referred to in paragraph (p)(1) of this section include:

- a. The Program for the Handicapped under section 199.5;
- b. The Active Duty Dependents Dental Plan under section 199.13;
- c. The Supplemental Health Care Program under section 199.16; and
- d. The TRICARE Enrollment Program under section 199.17, except for TRICARE Extra program under that section.

3. Exemptions to the restriction. In addition to the provision to make TRICARE Extra available to CHCBP beneficiaries, the following two demonstration projects are also available to CHCBP enrollees:

- a. Home Health Care Demonstration; and
- b. Home Health Care-Case Management Demonstration.

Q. PREMIUMS.

1. Rates. Premium rates will be established by the Assistant Secretary of Defense (Health Affairs) for two rate groups - individual and family. Eligible beneficiaries will select the level of coverage they require at the time of initial enrollment (either individual or family) and pay the appropriate premium payment. The rates are based on Federal Employee Health Benefit Program employee and agency contributions required for a comparable health benefits plan, plus an administrative fee. The administrative fee, not to exceed ten percent of the basic premium amount, shall be determined based on actual expected administrative costs for administration of the program. Premiums may be revised annually and shall be published annually for each fiscal year. Premiums will be paid by enrollees quarterly.

2. Effects of failure to make premium payments. Failure by enrollees to submit timely and proper premium payments will result in denial of continued enrollment and denial of payment of medical claims. Premium payments which are late 30 days or more past the start of the quarter for which payment is due will result in the ending of beneficiary enrollment. Beneficiaries denied continued enrollment due to lack of premium payments will not be allowed to reenroll. In such a case, benefit coverage will cease at the end of the ninety day (90) period for which a premium payment was received. Enrollees will be held liable for medical costs incurred after losing eligibility.

R. TRANSITIONAL PROVISIONS.

1. There will be a sixty-day period of enrollment for all eligible beneficiaries (outlined in paragraph D.1. of this section) whose entitlement to regular military health services system coverage ended on or after August 2, 1994, but prior to the CHCBP implementation on October 1, 1994.

2. Enrollment in the U.S. VIP program may continue up to October 1, 1994. Policies written prior to October 1, 1994, will remain in effect until the end of the policy life.

3. On or after the October 1, 1994, implementation of the Continued Health Care Benefit Program, beneficiaries who enrolled in the U.S. VIP program prior to October 1, 1994, may elect to cancel their U.S. VIP policy and enroll in the CHCBP.

4. With the exception of persons enrolled in the U.S. VIP program who may convert to the CHCBP, individuals who lost their entitlement to regular military health services system coverage prior to August 2, 1994, are not eligible for the CHCBP.

S. PROCEDURES. The Director, OCHAMPUS, may establish other rules and procedures for the administration of the Continued Health Care Benefit Program.

DEPARTMENT OF DEFENSE
PUBLICATION SYSTEM
CHANGE TRANSMITTAL

OFFICE OF THE SECRETARY OF DEFENSE
Assistant Secretary of Defense for Health Affairs

CHANGE NO. 1
to July 1991, print
DoD 6010.8-R - 3
March 22, 1995

CIVILIAN HEALTH AND MEDICAL PROGRAM
OF THE UNIFORMED SERVICES (CHAMPUS).

Change 9.

AD-A 268 634
The Assistant Secretary of Defense for Health Affairs has authorized the following page changes to DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," July 1991 (Reprint).

PAGE CHANGE

Remove: Pages 4-i through 4-67, 6-i through 6-36, 13-i through 13-37, and 14-i through 14-34

Insert: Attached replacement pages and new pages 4-68 through 4-81, 6-37 through 6-57, 13-38 through 13-44, and 14-35 through 14-38

EFFECTIVE DATES

The above changes are effective on or after:

1. Dental Benefit Plan retroactively back to April 1, 1993
2. Authorized Provider and Provider Reimbursement Methods, April 6, 1995
3. Basic Program Benefits, October 1, 1995

B.C. Whitehead
B.C. WHITEHEAD
Director
Correspondence and Directives

Attachments
237 pages

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, THIS TRANSMITTAL SHOULD BE FILED WITH THE BASIC DOCUMENT

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